PUBLIC HEALTH NURSING

FEBRUARY
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The National Organization for Public Health Nursing is a membership organization composed of individual and agency members. Its purpose is to serve as a clearing house of information, and to develop and interpret standards for personnel and practices in public health nursing. This is accomplished through an advisory service to individuals and agencies interested in public health nursing; through publications, including the official magazine, PUBLIC HEALTH NURSING, and through connections with national, state, and local agencies in related fields. The organization is administered by an elected board of lay and professional members. Its activities are carried on by committees representing public health nursing and related fields, and by an employed staff.

The organization has no jurisdiction over its membership. It serves in a purely advisory capacity. The acceptance of any of its recommendations is entirely voluntary.

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PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

Nursing in the National Security

IN TIMES OF crisis when every hour may see a change in world conditions a magazine that goes to press two months before its date of issue labors under a handicap. The daily newspapers have been reporting on the Armed Forces' need for nurses. In this issue you will find statements prepared by the professional nursing organizations on mobilization of nurses. The overall statement was issued by the Joint Committee on Nursing in National Security. In this the findings and recommendations of all six national nursing organizations are incorporated. The NOPHN statement concerning public health nursing appears on page 69.

The organizations worked at top speed to produce these materials for the National Security Resources Board and for the use of all planning groups during the emergency period. As soon as they were ready they were sent to constituent bodies also. The ANA mailed copies to the SNAS, the NOPHN to SOPHNS, et cetera. Before the material could be studied and circulated among the nurses within the states the military situation had changed and the Army sent out an urgent call for nurses.

Using the data collected by all the nursing organizations and applying the principles agreed to by the Joint Committee the SNAS were quickly able to establish quotas of nurses who could be released by each state to care for military casualties *now*. It was possible also to designate the number of nurses needed from the field of general duty, the number of supervisors and head nurses, nurse anesthetists, operating nurses, and psychiatric nurses.

Public health nurses may wonder why a quota was not set for them. In answer to this appeal for nurses to volunteer this point has been given serious thought and the recommendations made that public health nurses be called into the Armed Services only as their skills are needed and that they be considered *essential* in helping to maintain civilian health, whether there be limited or fullscale mobilization. The reasons are outlined on page 70.

There apparently is little need now in the Armed Forces for the special skills and preparation of public health nurses. There *is* mounting need for public health nursing services in communities where wartime problems are reappearing. With the possibility of enemy attack of our country the home front assumes greater importance than even in World War II. Civil defense directors are counting on public health nurses to assume leadership in emergencies. The nurse who knows how to work with groups of people, how to organize and teach volunteers and other types of lay workers, how to help a family develop its own skills and resources to keep its own members well and to nurse the ill has a new responsibility to her country, her profession, to all those whom she daily serves, and to herself.

A refrain comes back from the past: Keep the home fires burning. As we turn the midcentury mark and enter this momentous 1951

it seems to be the main job of the public health nurse to devote herself to the welfare and happiness of the American family, even though it means she must sacrifice the personal satisfaction that comes from service to the fighting men.

Progress in Structure

READING THE FIRST report of the Joint Coordinating Committee on Structure (page 86) should be a satisfying experience. Running throughout it is the theme of unity. It is a report of the growing closer together in their thinking and approach of all the representatives on structure committees. Certainly there still is a big job to be done before the final design will be outlined but we now are at a stage where more is behind us than before us in the reorganizational activities—and this is heartening.

Take, for instance, the simple sentence in the report: "The committee has agreed that the key words in determining the difference [in the objectives of the two new organizations] are *nurse practice* and *nursing services and education*." It is a simple statement only because of the clarity of vision and keen analysis behind it. Actually it takes us over a fundamental point which might well have been an unsurmountable hurdle.

Final decision on all committee action and recommendations rests with the members of each organization. The boards of directors make important decisions about next steps as we proceed. The progress displayed now in all deliberations regarding structure is stimulating and promises well for the future of the nursing organizations.

At the December meeting of the NOPHN Committee on Structure careful consideration was given to the objectives of the new organizations as tentatively outlined by the Coordinating Committee. Many suggestions and some questions were raised and presented to the board at the January meeting. There will be a continuous need for close coordination in the planning, promotion, and projects of the two new organizations as there are bound to be areas of common interest, for there never will be a sharp differentiation between nurses and nursing or between practice and organized services and nursing education.

Brotherhood Week—February 18, 1951

WE TALK ABOUT building bridges of brotherhood around the world in answer to the communist pretensions, and that's a splendid vision. But brotherhood begins on a man to man basis at home and not a mass to mass basis across the oceans. Without that footing, it is idle talk and an empty vision.

We can't afford to blind ourselves to the disturbing and undermining racial and religious antagonisms in America. They will defeat our good intentions for a world brotherhood until we cast them out and live as brothers in our states, communities, and neighborhoods—not for a single week in any year, but day by day and year by year.

ERIC JOHNSTON, *Chairman*
Brotherhood Week

Nursing in Civil Defense

RUTH B. FREEMAN, R.N.

NURSING CARE WOULD unquestionably be a great factor in the saving of life in the event of a wartime attack from the air. Nurses would be called on to give immediate care to the sick and injured, assist with screening and evacuation, and at the same time care for the "normal" sick. To prepare for such an emergency, nurses should secure special training and participate in community civil defense planning.

All over the United States civil defense plans are moving forward. Every state, possession, and territory has now named a civil defense director or authority; almost every state has named a medical director. Nursing is well represented in planning groups and in the various civil defense organizations.

Guided by the official publication, "Health Services and Special Weapons Defense,"[1] national, state, and local authorities are basing their plans on the expansion of existing facilities rather than the creation of new ones to meet civil defense needs. Thus, the medical director for civil defense is frequently the state or local health officer or someone delegated by him. Plans for first aid education and instruction in home care of the sick, traditionally a responsibility of the American National Red Cross, continue to be carried in large measure by that organization.[2] Nurses are taking much responsibility for planning for the care under wartime conditions of those who may be injured or ill. Nursing care will unquestionably be a great factor in the saving of life should such an emergency occur.

Miss Freeman is nursing consultant, Health Resources Office, National Security Resources Board, Washington, D. C.

Planning Based on Possible Atomic Attack

While it cannot be certain that atomic weapons would be used in any attack, this possibility is usually the basis for planning of medical and nursing care. This is an entirely logical basis for planning inasmuch as the problems arising are almost identical with those following attacks with "conventional" weapons except in timing and degree. With the use of atomic weapons immediate, devastating effects are produced—the difficulties are overwhelming, and the need for medical care concentrated. However, except for radiation effects which constitute a relatively small part of the total damage, the type of care needed is the same. Therefore, plans made for coping with the results of atomic attack may be equally useful in dealing with problems arising from other enemy action. Plans for defense against such unconventional means of attack as the use of bacterial and chemical weapons have also been developed and will be released at a later time.

The Medical Problem

Any computation of probable casualties and incidence of particular types of injury or illness under wartime conditions must represent a very rough estimate. The casualties at Hiroshima, for example, occurred in a situation in which the population was unwarned, organization for care minimal, and construction of buildings different from that commonly found in an American city. The effectiveness of the saturation bombings in Germany depended upon a particular combination of circumstances that might not be duplicated in another country at another time.

Casualty estimate

The nursing problems that would arise under conditions of atomic warfare are not new. They are problems of quantity rather than kind. A total of 141,000 casualties[3] occurred at Hiroshima. The number which might be expected in any American city suffering atomic attack would depend upon several factors:

1. The concentration of population. Such weapons are usually directed at larger population centers.
2. The time of day at which the explosion occurs. During daytime hours population tends to be concentrated in the center of town which is the logical target. At night population is much more dispersed.
3. The height of the point of explosion of the bomb. An air burst is considerably more effective in damage to structures and personnel than either a ground or underwater burst and is therefore usually considered the delivery of choice.
4. The amount of protection afforded by buildings and shelters.
5. The amount of warning and the ability of the population to seek shelter without panic or confusion.

However, casualties in the tens of thousands may be anticipated—a situation with which we have had no experience to serve as a precedent for action.

Types of injury

The types of injury that might be expected in order of incidence are:

1. Burns. It is estimated that approximately 60 percent of the living casualties would be suffering from burns.
2. Mechanical trauma. It is estimated that approximately 50 percent of the living casualties would be suffering from mechanical trauma.
3. Radiation injury or illness. It is estimated that approximately 20 percent of the living casualties would be suffering chiefly from radiation injury.

Burns may be flash burns due to the thermal results of the explosion itself or flame burns due to contact with clothing or other materials ignited as a result of the tremendous release of energy in the form of heat at the time of the explosion. Secondary fires due to damage to electrical equipment or released cooking gas may also be a significant factor in producing flame burns. Burns will vary in degree and extent and will respond to the same treatment as burns caused by other means. Flash burns, for example, resemble sunburn.

Considerable research is going forward in laboratories and clinical centers on the treatment of burns to arrive at a method that has maximum effectiveness in mass care (easy to carry out, using easily available supplies). Civil defense supply lists are based on the use of a dry cellulose pad dressing held in place with a tensile yarn bandage.

Trauma would probably consist of fractures, crushing injuries, cuts from flying glass and other debris, and bruises from falling objects displaced by the blast following explosion.

Radiation injury and illness may affect those who are within one mile of the center of the explosion and have not been shielded from the harmful rays released at the time of the explosion. While radiation damage occurs immediately its symptoms or effects will not usually be apparent at once, and intensive care is not required in the immediate post-explosion period. While contamination due to residual effects of radiation may occur following a ground or underwater bomb burst, since these types of delivery are less effective than an air burst, the most likely problem would result from the acute radiation damage at the time of explosion.

Emotional guidance must be included in the overall immediate care. The nurse can do much to allay hysteria and combat despair by her own attitude and by applying the same mental hygiene principles effective in other situations of stress.

The Nurse's Job

Nursing problems anticipated in the event of an atomic explosion include:

1. Providing immediate care for the sick and injured
2. Assisting with screening and directing patients to facilities for further care
3. Assisting with the evacuation of the sick and injured
4. Providing continuing care for the injured or ill

5. Providing nursing care for the "normal" sick
6. Giving supervision or care in shelters and billets.

Obviously, *immediate care of the sick and injured* under conditions of such magnitude must be of a minimal emergency nature. Professional nursing care and even supervision may have to be temporarily withheld from those patients who are desperately ill but moribund—a choice that is contrary to ethical concepts deeply inculcated in nurses. Shortages of equipment, supplies, and personnel will necessitate much improvisation. Water supplies may be cut off, hospitals destroyed, sterilization equipment unavailable.

During the immediate emergency period nurses will have to depend on assistants to do most nursing procedures under professional direction. Taking temperatures, providing warmth, reassurance, and liquids to victims of shock, applying dressings, preparing patients for medical examination or treatment, are examples of services that would be rendered by nurses aides or volunteers without special training. For some procedures, a second line of supervision may be used; for example, an experienced nurses aide might supervise untrained volunteers who are performing a particular service such as temperature-taking.

Screening and routing of patients is another important facet of care. Nurses, in coordination with physicians and in some instances with physicists, will be called upon to separate patients according to the type and amount of care needed and the urgency of the need.

Evacuation of sick and injured might be expected to be a problem of great magnitude, both because of the tremendous numbers needing continuing care and because of the destruction of many ordinary facilities. Nurses will be required to supervise the care of patients who are awaiting transportation at evacuation collection centers and will also be called upon to guide the loading of patients into evacuation vehicles. This latter task requires good judgment since it would be necessary to load patients selectively with regard to the type of supervision available in transport and the physical strain involved in different types of transport. Some nurses will also be required to serve en route on trains, planes, and busses to care for the seriously injured or ill.

Continuing care of the injured and ill will present many problems. Severe and extensive burns, for example, require not only good immediate treatment but longtime care of high quality. Much of the continuing care would be provided in hospitals well outside the bombed area. For this reason nurses in every community might be expected to share in the increased burden. Because this patient load must be superimposed on the usual sickness load of a community, facilities and personnel will be taxed to the utmost. The greatly extended use of nurses' assistants of various types would seem inevitable. The reduction of professional nursepower due to withdrawal for military service would further emphasize the need for auxiliary workers.

Most care of radiation sickness—care that extends over weeks or months—would be provided in outlying hospitals, since those with less than lethal doses of radiation can be moved out of the bombed area at once and would not require care for several days after the explosion.

During emergency periods, the *"normal" sickness* within a community continues. Diabetic patients need insulin, parturient patients deliver, upper respiratory and chronic illnesses occur as usual. However, two factors will make the care which can be provided for these patients different from that in non-emergency times. First, institutional facilities cannot be as freely used. Hospital beds must be taken from the less seriously ill to make way for graver cases. While emergency hospitals will care for immediate problems, selective admission and earlier discharge will have to be practiced to make available the great bulk of facilities needed for continuing care of the seriously injured and ill.

This curtailment would inevitably place a great responsibility for care upon the home. The public health nurse would find her caseload of acutely ill patients greatly increased, and supervision of home care of the sick may assume major importance. Advance teaching of homemakers and other family members in home care of the sick will make them less dependent on professional guidance and thus

reduce the need for intensive home visiting.

Secondly, with the tremendous increase in the total number of individuals needing care, professional services must be given with great selectiveness. Full use must be made of family members, volunteers, nurses aides, and other auxiliary workers for home care of illness and injury. In institutions such as schools and industrial plants, minor treatments may be given by selected nonnurse workers with only occasional direction from the professional nurse.

Shelters and billets for refugees or for children or old people evacuated from the danger areas would need supervision, and public health nurses would undoubtedly play an important role in such work. People who are serving in homes or other buildings used for the care of displaced persons will need instruction in group care, in recognition of illness, in environmental sanitation, nutrition, and the care of children, the aged, and the ill.

While this discussion has been based on the anticipated results of atomic attack, the nursing problems would not vary greatly if other weapons were used. Nurses can do much to prepare to meet these problems effectively by securing necessary training themselves, by training auxiliary workers in large numbers, and by participating actively in community planning for civil defense.

Suggested reading: "Nursing Care following Massive Exposure to Ionizing Radiation" by Ruth B. Freeman in the *AJN*, February 1950.

BIBLIOGRAPHY

[1] Federal Civil Defense Administration. Health services and special weapons defense. FCDA Publication Ag.-11-1, 1950. 260 p. U. S. Government Printing Office, Washington 25, D. C. 60 cents.

[2] American National Red Cross. American Red Cross Nursing Services. Washington, D. C., ARC, February 1949. 24 p. Free to local chapters.

[3] Effects of atomic weapons. Prepared for and in cooperation with the U. S. Department of Defense and the U. S. Atomic Energy Commission under the direction of the Los Alamos Scientific Laboratory. Revised September 1950. U. S. Government Printing Office, Washington 25, D. C. 456 p. $1.25.

What Are You Saying? . . .

Are we too professional when we speak? Do fellow workers, parents, patients, board members understand *exactly* what we mean? This column is designed to challenge us. Its purpose is also to help the reader become familiar with the new connotations of words and to clarify and sharpen communication media. Its growth will depend on *your* interest. What words would you like included? Send as many as you like. Here are a few examples with their varieties of meaning:

Activity: A state of being active. Doing our daily dozen? Doing the dishes? Our job? Going to the theater or entertaining? Learning to play the piano? OR the number of hours a TB patient can work or another patient be up and about? An agency's caseload?

Discipline: Does it mean punishment? Self-denial? Blind obedience? Control over behavior? The rules which affect conduct or action? A skill requiring disciplined fingers? OR does it mean a profession, such as law, social work, medicine, or nursing?

Empathy: How does it differ from sympathy? Antipathy? OR is it the power which enables one to treat subjects objectively, apart from his own feelings and personality?

BEATRICE HEATON, R.N.

Mobilization of Nurses for National Security

A Statement Prepared by Joint Committee on Nursing in National Security*

NURSING HAS BEEN placed on the list of critical occupations by the U. S. Department of Labor. Careful planning so that sound nursing education will be continued and nursing service will be wisely used and distributed therefore becomes of the utmost importance to national security.

With these facts in mind the six national nursing organizations* have jointly prepared this statement of policies that they believe should govern the mobilization of nurses and the distribution of nursing service. The statement considers both quantitative and qualitative standards. It is based on three general assumptions:

1. That military needs must come first, provided the military services agree on reasonable quotas, recruit personnel according to functional category and field of nursing, and make full use of men nurses and auxiliary workers.

2. That, if there is full-scale war, civilians as well as soldiers may be on the battlefront; thus nursing service for civilians may be as critically essential as service for the Armed Forces; and thus it will be important to maintain a reasonably adequate distribution of nurses throughout the country for both civilian and defense requirements.

3. That, in the event of total mobilization, the country will have some form of regulation, voluntary or governmental, so that there will be systematic allocation of supply among all essential services.

What Must Be Done to Provide the Nation with Minimum Nursing Service

It is estimated that 316,500 professional nurses are now employed in the United States to give service to civilians. This number is inadequate under present conditions and would be woefully inadequate if full-scale war should develop and a consequent drain on nursing services be required by the Armed Forces. To meet not only present but increased demands, the country should have at least 65,000 more professional nurses than are currently employed, without making any allowance for expanding military needs in the event of total mobilization.

If the nation is to attain the minimum number of qualified nurses essential both now and for the future, if nursing service of the proper quantity and quality is to be provided when and where it is most needed, many major adjustments and measures will be called for.

The six national nursing organizations recommend:

1. That all possible means be developed for recruiting more students for schools of nursing.

The problem of recruiting more students for schools of nursing is urgent. The nurse supply should be increased to make up the

* A Joint Committee of the Six National Nursing Organizations: American Association of Industrial Nurses, American Nurses' Association, Association of Collegiate Schools of Nursing, National Association of Colored Graduate Nurses, National League of Nursing Education, and National Organization for Public Health Nursing.

current deficits in essential services, to keep up with the needs of a growing population, and to permit nursing participation in research that will affect the care and treatment of patients. In the event that present hostilities spread, the nurse supply must be further increased to provide for additional military nursing needs without endangering nursing service for civilians. Recruitment of students for schools of nursing is the responsibility of the nursing profession, allied groups, and the public.

2. That a program be instituted immediately for encouraging inactive nurses to return to nursing practice.

Nursepower can be greatly increased by encouraging a maximum number of inactive nurses to return to practice either fulltime or parttime. As of 1949 there were an estimated 205,517 inactive professional nurses. Although some are in the older age group and some have extensive family responsibilities, most constitute a reserve from which nursing services can draw. A program to influence them to return to active duty and to take refresher courses should be started immediately. This may require governmental support for nursery schools and other child care facilities.

3. That as many practical nurses be trained and employed to help professional nurses as hospitals and other community agencies can utilize to good advantage.

Since professional nurses can carry their responsibilities only if they have help from allied workers, qualified practical nurses should be trained and employed wherever feasible to work under the supervision of professional nurses in giving bedside care to selected patients. Although the exact number of trained practical nurses is not known, it is certain that the supply is inadequate for the demand. More facilities for providing sound practical nurse training are among the most pressing needs.

4. That nurses be withdrawn systematically from the civilian services for military duty according to a plan that ensures their employment at the highest level of skill for which they have prepared.

Withdrawal of nurses from the civilian supply should be carried on according to a careful plan. Waste of skills that are critically needed for civilian health programs, but not critically needed for military programs, should be avoided. Each nurse should be classified both by functional category and by type of service. Recommended categories are: staff nurse, supervisor (including head nurse), instructor, and administrator (including chief nurse). Recommended classifications by type of service are: general (including nurses prepared by education or experience in nursing in medicine and surgery, pediatrics, obstetrics, communicable diseases, outpatient department), operating room, nurse anesthetist, psychiatry, orthopedics, public health nursing, industrial nursing. Quotas should then be drawn up for these functional categories and types of service.

5. That state and local advisory boards of nurses be organized and be given the authority by the government to review assignment of nurses to the Armed Forces and to civilian agencies.

6. That, if there is total mobilization, nurses be redistributed within the fields of nursing and within community agencies so that the most essential civilian needs will be taken care of first.

Since the most essential services should have top priority, some redistribution of nurses within fields of nursing, community agencies, and geographic areas may be necessary. We cannot afford to let any strategic area or any particular group of citizens or individuals have care at the expense of those with more urgent needs. Some method, either voluntary or governmental, of allocating professional and practical nurses and auxiliary personnel may be necessary if nurses and allied workers are to be available where the need is greatest.

7. That major effort be directed to improving sound basic nursing education and to increasing enrollment in schools of nursing that offer effective programs in such education.

To allow any interruption in nursing education even during a national emergency is to endanger the future health of the country and to run the risk of having substandard nursing care in the future. Long-range considerations should not be sacrificed exclusively to the short-range.

In order that the present supply of faculty, teaching facilities, and funds (now dangerously low) will not be dissipated, it is essential that enrollments be increased only in those schools that offer effective programs. These are (a) basic diploma schools (b) basic degree schools and (c) schools for practical nurses.

8. That selected nurses be encouraged to prepare for responsibilities as teachers, supervisors, and administrators, as well as for the special fields, in order to safeguard essential nursing service.

If more student nurses are to be prepared not only must the present number of faculty be retained but new instructors must be recruited and prepared. If nursing services are to be safeguarded and are to be ready to assume added responsibilities, new personnel must be recruited and prepared for essential supervisory and administrative posts and for the special fields that require preparation beyond that given in the basic school. It is therefore necessary that there be more qualified graduate nurses enrolled in advanced educational programs that will prepare them for increased responsibilities and for nursing specialties.

It is also important that special courses be given for all nurses so that they may be equipped to care for people if there is enemy bombing and to help civilians assume responsibility for taking care of themselves in time of sickness or possible attack.

9. That administration of nursing services be improved so that nursing skills will be used to the best advantage and their full value reach more people.

As the drain on America's nursing and medical resources becomes necessarily greater, institutions and other community health agencies employing nurses will find it increasingly important to review administrative policies in the light of changing conditions. If there is stepped-up mobilization many nursing services may require complete reorganization. Nursing service must be shared among as many persons as possible in order to reach those who most need it, and any nonessential service must be eliminated.

Wherever possible, nonnursing personnel should perform nonnursing duties. If nurses are spending time on nonnursing duties, such as clerical work or housekeeping, their professional skills (which are scarce and have been acquired at great cost and time) are being wasted. To avoid such waste more dietitians, clerks, nursing aides, wardhelpers, pantry maids, and messengers should be employed in hospitals to relieve nurses; the services of nonnurse science instructors should be used in schools of nursing; more clerks should relieve nurses in public health nursing agencies; and nonprofessional personnel (especially nurses aides) should be employed in industrial medical departments to assist with duties that do not require professional nursing skill.

10. That nursing service be stabilized as much as possible and turnover of staff held to a minimum through the adoption and application of sound personnel policies for nurses and allied workers.

Sound personnel policies will be a vital factor in bringing inactive nurses back to practice and in holding nurses and their allied workers in the institutions and agencies where they are most needed. It is imperative that personnel policies be designed to help make working conditions attractive and that salaries be adequate in order to compete with those paid to industrial production workers. Particular attention should be directed to holding auxiliary personnel in hospitals even in the face of competing demands for their services from industry. Without adequate auxiliary personnel, it will be impossible to give even the most essential nursing care.

11. That there be an active program to secure the cooperation of physicians, hospitals, public health authorities, and the general public in ration-

ing nursing service to cover the most essential needs.

Effective rationing and redistribution of nursing service will depend largely upon the understanding and cooperation of physicians, hospitals, public health authorities, and the general public. For instance, if private duty nursing is reserved only for the critically ill, as recommended, physicians and patients must understand the reasons and be willing to cooperate. Major effort should be directed to promoting such understanding and cooperation.

12. That, since nursing has been designated by the U. S. Department of Labor as a critical profession, those nurses assigned to civilian services and those assigned to the Armed Forces be given equal recognition and privileges regarding educational and future employment benefits.

13. That studies be instituted immediately to provide a sound basis for planning.

14. That, if nurses are assigned in accordance with the suggestions made in this statement, some insignia be designed by government for use by nurses assigned to civilian agencies.

Number of Professional Nurses Needed to Provide Minimum Civilian Service

The number of professional nurses needed for the kind of job that should be done to protect civilian health and to give adequate care is not attainable at this time. It is a goal at which we may aim for the distant future. Right now we must stay within the realm of the practical. Accordingly, the following estimate of the number of professional nurses necessary to maintain civilian health programs is absolutely minimum in view of possible future national developments. The numbers have been worked out by representatives of the various fields of nursing with thoughtful consideration of many factors, including total nursing needs.

Total	381,886
Nonfederal hospitals (general, allied, and special) and educational programs in nursing	237,339
Public health	30,000
Industrial	18,000
Private duty	53,000
Other (including office)	27,000
Federal civilian hospitals	16,547

No consideration has been given to the increased needs of veterans hospitals. These will probably depend on the length of time patients stay in military hospitals and on the number evacuated to veterans hospitals.

Number of Trained Practical Nurses Needed to Provide Minimum Civilian Service

The number of trained practical nurses in the United States is not known. It is therefore not possible to give a reliable estimate of the number of trained practical nurses needed nationally for minimum civilian service.

That many more trained practical nurses will be needed than are now available is a certainty. The estimate of the number of professional nurses just given is based on the assumption that a sufficient number of trained practical nurses will be employed in hospitals and other institutions and in public health nursing agencies to supplement professional nursing care.

Practical nurses will not be needed in industry because it is recommended that industrial nursing services be limited to the care of injuries and illnesses and to a preventive program only sufficient in scope to keep workers on the job at maximum production. These are activities that require professional nurses. There are nonnursing duties in industrial medical departments, but they do not require personnel as fully trained as practical nurses. These duties can be performed by nurses aides and other auxiliary personnel.

This article appears simultaneously in *The American Journal of Nursing*.

Public Health Nursing in the National Security Program

Prepared by National Organization
for Public Health Nursing

PUBLIC HEALTH nursing is an organized community service that authorities recognize as indispensable during war or peace for the protection of civilian health. Public health nurses give health guidance and part-time nursing care to persons of all ages and incomes, in homes, clinics and schools. They take part in community measures for the prevention and control of disease. They participate in educational programs for nurses, allied professional workers, auxiliary personnel (volunteer and paid) and community groups.

To provide these services in the United States 25,081 nurses are currently employed by public health nursing agencies. Of these, 12,726 are employed by local government agencies such as health departments; 5,029 by local voluntary agencies such as visiting nurse associations; 5,852 by local boards of education; and the remainder by state and national agencies, universities, and schools of nursing.

Number of Public Health Nurses Needed for Limited Mobilization

Although the total number of 25,081 is an all-time high, it is still far below the minimum number of public health nurses needed to meet the basic requirements of our present population. The number represents a ratio of only one public health nurse to approximately every 6,000 persons; whereas it is generally recognized that at least one staff public health nurse is required for every 2,000 to 5,000 persons, depending on local health conditions, on whether a community public health nursing program includes home bedside nursing care of the sick as recommended by authorities, and on how many practical nurses are employed by public health nursing agencies to help give bedside care to selected cases.

The number of public health nurses currently employed is also seen to be inadequate for even minimum needs when it is realized that many authorized nursing positions in public health nursing agencies are as yet unfilled. According to "Report of State Health Program, 1949," issued by the Public Health Service, only 70 percent of planned positions in official agencies were filled in 1948. Then too, as of January 1, 1950, rural sections of 715 counties, with a total population of more than 7,000,000, as well as 18 incorporated cities and towns, each with a population of 10,000 or more, still had no fulltime public health nursing service. Whether we have partial or total mobilization, these areas, no less than others in the country, should have public health nursing service in order to take care of the most critical civilian needs.

In view of these facts and accepting a ratio of one public health nurse to 5,000 as a minimum, the United States should have at least 30,000 public health nurses, or 4,900 more than are now employed by public health nursing agencies. Since approximately 1,700 nurses are annually entering public health nursing, it is reasonable to expect that this minimum goal of 30,000 can be achieved within the next few years provided there is only limited mobilization without full-scale

war and provided intensive efforts are made to recruit nurses for the public health field and to keep students in nursing schools and in public health nursing programs of study.

Number of Public Health Nurses Needed if There is Total Mobilization

If full-scale war develops the goal of 30,000 public health nurses would doubtless be impractical to achieve. But everything possible should be done to retain the present number of 25,081 public health nurses even though military needs must first be met and redistribution of public health nurses currently employed may be imperative.

Reasons Why Public Health Nurses Are Essential

These are the reasons why public health nurses should be considered essential in helping to maintain civilian health whether there is limited or full-scale mobilization:

1. Parttime public health nursing care of the sick in their homes will be more important than ever as a means of relieving pressure on hospitals and of stretching professional nursing service as far as possible among the greatest number of persons.

As the nation gears its planning to expanding emergency needs, as the drain on America's medical and nursing resources becomes necessarily greater, hospitals will undoubtedly find it necessary to send patients home while they still need professional nursing care. Provided they have the necessary staff, public health nursing agencies will be able to give this home care on a parttime basis. They will also teach members of a patient's family or others to give him additional needed care while the public health nurse is not there. In this way seven or eight families can share the services of one professional nurse during the course of one day.

2. Through preparation or experience, or both, public health nurses have developed skills that make them especially valuable in helping families to help themselves during periods of national crisis.

Although bedside care of the sick in their homes is an important part of public health nursing, public health nurses are essentially health "supervisors." Their major duty is to help individuals and families do what they can to stay in good health, or if sickness strikes to take responsibility, under medical direction, for helping themselves as much as possible. Helping families to help themselves in time of sickness will be of added importance in order to minimize the drain on medical and professional nursing resources. Thus, public health nurses will be needed more than ever for this type of service.

3. In addition to the responsibilities that are customarily theirs, public health nurses will increasingly have many added responsibilities if there is total mobilization.

Not only target areas but industrial and military centers with congested and expanding populations will undoubtedly be threatened with critical health problems in whose prevention and control public health nursing is an important factor. These communities, and many others as well, may need special emergency control measures requiring public health nursing service, skill, and organizational ability.

If the experience of World War II can be used as a guide many more babies than during normal times will be born to mothers in need of public health nursing care and guidance. Often these mothers will be very young and in strange surroundings far away from home and friends.

Also, with the possibility of attack threatening our shores for the first time, an unprecedented number of civilians may require nursing care. Nurses must be on hand in local communities after emergencies are over to direct the mass nursing programs that may be needed, with the help of relatively untrained civilians. They will also be needed to go with any group that may be evacuated from target areas. Since public health nurses are experienced in community work and in community measures for the protection and control of disease, they will be among the first to receive instruction in the immediate care and

follow-up of casualties resulting from the newer weapons of warfare.

4. Because service during both emergencies and normal times can be given only with the help of an increased number of auxiliary nonprofessional workers, there must be well prepared nurses in public health nursing agencies to train and supervise them.

The demand for professional nurses may be even greater than during World War II. Therefore, qualified practical nurses, nurses aides, and auxiliary workers, both paid and volunteer, will be a vital factor in helping to carry on necessary civilian services. But in order to maintain the essentials of nursing and to protect health these workers must be trained and supervised by especially well prepared public health nurses. In some agencies the ratio of 1 qualified practical nurse to 10 professional nurses may be desirable. In other agencies, depending on local circumstances, 1 qualified practical nurse to 5 professional nurses may be possible.

5. Public health nursing represents an economical way of distributing nursing service among many people.

Although public health nurses constitute a relatively small proportion of the total number of active professional nurses in the United States (less than 9 percent) the number of people they serve is extensive. It is estimated that public health nurses serve 5,000,000 families, or 1 out of every 8 families in the nation, during the course of one year. To do this, they make approximately 17,500,000 visits to homes, in addition to their work in clinics, classes, conferences, and schools.

Recommendations Concerning Measures to be Taken by Authorities Responsible for the National Security Program

If the nation is to have the number of public health nurses considered indispensable for civilian services during either limited or full-scale mobilization, there must be sound planning based on a realistic appreciation of both military and civilian needs. There must be concern for seeing that public health nurses are employed at their highest level of skill and to the advantage of the greatest number of people. There must also be major effort to prevent interruption in education for public health nursing and to secure a regulated inflow of graduate nurses into the public health nursing field.

With these considerations in mind it is recommended that authorities responsible for the national security program in cooperation with the nursing profession and others:

1. Establish safeguards so that public health nursing faculty and teaching personnel, public health nurses with key administrative, supervisory, and consultant responsibilities, will be assigned only where their special abilities will be used at the highest level of skill.

   Since only a few of these personnel will be needed for the Armed Forces, most should serve in communities where their services will be critically essential.

2. Establish safeguards so that field nurses employed by public health nursing agencies will be assigned for military service only where their special abilities will be used.

   Since few nurses with public health nursing experience will be needed in the Armed Forces, field nurses should work in public health nursing agencies where their services will be indispensable in helping to maintain civilian health and to prevent and control disease.

3. Encourage the recruiting and training of new professional personnel, insofar as possible, to take the place of any personnel called to serve the Armed Forces or who leave public health nursing agencies for other important reasons.

   In order to keep the number of public health nurses up to even the present minimum level of 25,081 and to help guarantee that there will be a future supply of competent public health nurses, at least 1,500 nurses should enter public health nursing every year. As many as possible of these nurses should be recruited from among those who have received degrees or certificates upon completing approved educational programs

for public health nursing or who have graduated from collegiate schools of nursing.

4. Provide facilities for training public health nurses so that they will be ready to assume added responsibilities in time of crisis.

These responsibilities will include giving immediate and follow-up nursing care for civilian casualties that may result from atomic attack; giving emergency medical care if necessary; directing the work of relatively untrained groups in the mass nursing programs that may be necessary if enemy action hits this country; and accompanying and taking care of groups that may be evacuated from target areas.

5. Provide facilities for training a sufficient number of practical nurses, nurses aides, and auxiliary workers (paid and volunteer) who can help public health nurses give both normal and emergency service.

6. Recognize public health nursing personnel serving the Armed Forces and public health nursing personnel serving civilians as being on an equal footing, so that both will receive the same privileges in regard to educational and future employment benefits, such as credit ratings when civil service examinations are taken or equal tenure of position.

7. If there is total mobilization, authorize redistribution of public health nurses within communities so that the most critical public health nursing needs will be taken care of first.

General Adjustments to be Made by Public Health Nursing Agencies

In addition to national measures needed to help extend public health nursing service to the maximum for the good of the greatest number of civilians, there must be many adjustments by local public health nursing agencies. The National Organization for Public Health Nursing will recommend that local agencies in each community:

1. Collectively study their programs and agree on a plan by which the most essential services can be achieved with the greatest conservation of professional nursing personnel and any nonessential service eliminated.

2. Intensify the training of individuals and families so that they can help themselves as much as possible in time of sickness or possible atomic attack.

3. Give refresher courses for inactive nurses so that they will be able to return to active duty on staffs of public health nursing agencies.

4. Employ as many practical nurses and auxiliary workers as an agency can use to good advantage so that professional nurses, insofar as possible, will be carrying out only professional duties that nobody else can perform.

5. Give as much group service as possible through clinics, classes, and conferences, and through having patients come in to the agency office when they are able to be up and about but still in need of some nursing guidance and care.

We have given our children an incomparable heritage of independence, willingness to go out into new places among new people, willingness to stand on their own feet and answer for their own deeds. Now because the task ahead of them is even more exacting than any task which Americans have yet faced, we must use the knowledge which the new sciences of human behavior have given us to create the conditions of the strength that will be needed to give protection against loneliness, new sources within the self, new capacities for moving into the future which is the only earthly future to which a democracy can commit itself, a future in which only the general direction of the next step is clear, in which men have the faith to say, although the night is dark, and they are far from home,

"I do not ask to see
The distant scene
One step enough for me."

MARGARET MEAD
White House Conference

Breast Self-Examination

ROSALIE I. PETERSON, R.N.
GENEVIEVE R. SOLLER, R.N.
MARGARET F. KNAPP, R.N.

A FILM, "Breast Self-Examination," has been prepared by the National Cancer Institute and the American Cancer Society to teach women how to detect a lump in the breast at an early stage. Breast cancer is curable by surgery if caught in time. Eighty to 90 percent of proven cases can be saved by early discovery and prompt, adequate treatment. As it is, more than half of the approximately 50,000 women who develop breast cancer each year die within a five-year period. Since breast cancer begins as an accessible local tumor, it is relatively easy for the woman herself to discover the lump; elaborate tests are not necessary. In fact, nearly all breast lumps are now discovered by the women themselves, but all too often, if the lump is cancerous, not early enough.

The 16 mm. film, which utilizes sound and color, demonstrates how women may make regular self-examinations. Public health nurses, who have an important role to play in the nationwide program to teach the importance of breast self-examination, are being asked to serve as interpreters of the film.

How well the nurse uses this film depends on her broad knowledge of cancer. Her background may be supplemented by (1) reviewing the two films, "Breast Cancer: The Problem of Early Diagnosis" and "Breast Self-Examination" (2) studying the articles listed at the end of the suggestive outline given below (3) observing breast examinations in health centers and tumor clinics and (4) practicing breast self-examination herself.

The film has had wide publicity among medical and public health groups and has just been released for showings to women's organizations. It may be borrowed from state and local health departments and from the local or state division of the ACS.

During the past few weeks we have shown the film to approximately 1,000 women in both large and small groups to obtain their reactions to it. Opportunities were provided for a brief discussion of the problem of breast cancer prior to or following the showing, and also for questions from the audience. Their questions on methods of diagnosis, treatment, and rehabilitation, and the resources in their own communities led us to believe that women want more information about breast cancer in addition to that provided by this movie. On the basis of our experience we believe it might be desirable to hold two meetings with each group. The purpose of the first meeting is to present the problem of breast cancer and the woman's responsibility for early discovery, and to familiarize her with the technic of breast self-examination. The follow-up meeting might be planned to determine how well the instructions and technics are understood and practiced.

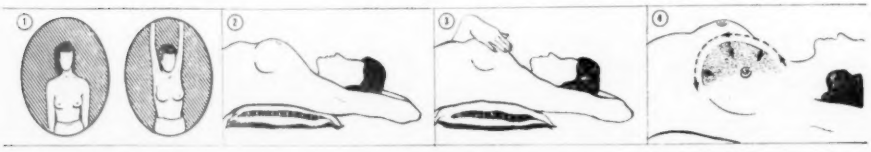
Because this movie presents unusual potentialities for group discussion the following suggestive outline of salient points has been developed as a supplementary tool to aid nurses in the discussion on "Breast Self-Examination."

Miss Peterson is chief, Mrs. Soller, assistant chief, Miss Knapp, formerly assistant chief, Nursing Section, National Cancer Institute, Public Health Service, FSA.

Suggestive Outline for Talk by Nurses on Breast Self-Examination

I. Create a healthy psychological attitude.
- A. Most lumps in the breast (2/3 of them) are not cancers.
- B. Only a physician can distinguish between a benign tumor and a malignant one.
- C. Tumors in the breast are in an accessible location. The woman herself is the best casefinder.
- D. Many thousands of women could save their own lives if they knew how to discover lumps in the breast early.
- E. Early cancer of the breast may be removed completely by surgery. If found early, 8 or 9 out of every 10 cases could be cured.
- F. Breast self-examination is a sensible health habit which helps to make possible the continued peace of mind necessary for a happy life.
- G. Success of early diagnosis and treatment depends to a great degree upon the woman's intelligence and initiative in seeking prompt, adequate medical care.
- H. Every woman has a share in the responsibility for teaching other women the importance of regular breast self-examination.

II. An acceptable method for breast self-examination:
- A. Step 1: Stand or sit before a mirror.
  1. Remove clothes to the waist line.
  2. Let your arms hang at your sides.
  3. Look:
     - a. To see whether the breasts are the same in size, position, and shape. One breast may normally be larger than the other.
     - b. To see whether the nipples are retracted.
     - c. To see whether one breast is higher than the other.
     - d. To see whether there is any dimpling or irregularity in the surface of the skin.
- B. Step 2: Raise the arms high above the head. Look for changes as described under II-A-3.
- C. Step 3: Lower the arms.
  1. Raise each breast so that the underside can be examined. Look for dimples, bulges, or other changes.
  2. Examine the nipples. Look for discharge, dimpling, puckering, rash, or sore.
- D. Step 4: Lie flat on your back on the bed.
  1. Place a folded bath towel or small pillow under the left shoulder. The towel or pillow helps balance and spread the breast tissue flat against the chest wall.
  2. Place left arm under the head, palm up.
  3. With the flat of the fingers of the right hand gently feel the tissue in the left breast. Start each time from the nipple line to the breast bone until the entire inner half of the breast from the collar bone to the lower edge of the breast has been felt. Gently and thoroughly feel for lumps or abnormalities.
- E. Step 5: With the towel or pillow still in place lower the left arm to the side.
  1. Gently feel outer half of breast from nipple line to outer edge of breast with the flat of the fingers until the entire outer half of the breast has been felt from bottom to top.
     - a. Pay close attention to the upper outer quarter of the breast as *this is where most lumps occur.*



b. Feel for lumps or abnormalities.

F. Step 6: Remove the towel or pillow. Place it under the right shoulder and repeat procedures D and E for the right breast.

G. Step 7: If a lump is felt see your physician at once.

III. Important points:

A. Examine the breasts at the end of the menstrual period. During and just preceding the menstrual period the breasts may be swollen and tender.

B. Examine the breasts monthly.

C. Every woman should examine her breasts regularly.

D. It is particularly important for women in the older age groups and especially after the cessation of the menses. The greatest incidence of breast cancer occurs over age 45.

IV. General information:

A. Cancer is a destructive, malignant growth.

B. There is no definite evidence that breast cancer in human beings is caused by any germ or virus.

C. It is neither contagious nor infectious.

D. There is no reliable evidence that breast cancer in humans is inherited.

E. Not all lumps are malignant—most of them are not.

F. Factors favoring development of breast cancer:

1. Women are more likely to have cancer at 45 years and over.
   a. About 80 percent of breast cancer occurs after the menopause.
   b. It is rare before the age of 25.
2. Some parts of the body, such as stomach, female reproductive organs, and the breast, seem to be unusually susceptible to cancer.
3. Breasts that have never given milk are more apt to develop cancer.

G. Cancer is curable if it is discovered and treated early.

V. Cancer of the breast.

A. The breast is the second most common site of cancer in women.

B. It is one of the easiest to find since it is in an accessible site.

C. No elaborate tests are needed.

D. It can be found by the woman herself. In fact, 98 percent of breast lumps are found by the patient.

E. Eighty to 90 percent of cases could be cured if found early and treated immediately.

F. First sign is a painless lump.

VI. What can you do?

A. Learn to examine your own breasts regularly.

B. For comfort wear a properly fitting uplift brassiere.

C. Have a periodic health examination which includes breast and pelvic examinations.

D. Become interested and actively participate in community programs for health promotion.

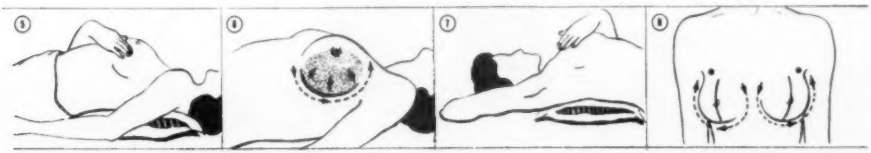
A lump in the breast is the woman's personal concern. Public health nurses have unlimited opportunities for teaching women the importance of finding a lump in the breast early. Because breast cancer can be controlled every woman should be motivated to make breast self-examination a health habit. Someday it may save her life!

RECOMMENDED READINGS

Haagensen, C. D. Carcinoma of the breast. *The Journal of the American Medical Association*, v. 138, September 18, 1948, p. 195-205; September 25, 1948, p. 279-292.

American Cancer Society in cooperation with the National Cancer Institute of the United States Pub-

(Continued on page 93)



Pledge to Children

Midcentury White House Conference on Children and Youth

TO YOU, our children, who hold within you our most cherished hopes, we the members of the Midcentury White House Conference on Children and Youth, relying on your full response, make this pledge:

From your earliest infancy we give you our love, so that you may grow with trust in yourself and in others.

We will recognize your worth as a person and we will help you to strengthen your sense of belonging.

We will respect your right to be yourself and at the same time help you to understand the rights of others, so that you may experience cooperative living.

We will help you to develop initiative and imagination, so that you may have the opportunity freely to create.

We will encourage your curiosity and your pride in workmanship, so that you may have the satisfaction that comes from achievement.

We will provide the conditions for wholesome play that will add to your learning, to your social experience, and to your happiness.

We will illustrate by precept and example the value of integrity and the importance of moral courage.

We will encourage you always to seek the truth.

We will open the way for you to enjoy the arts and to use them for deepening your understanding of life.

We will work to rid ourselves of prejudice and discrimination, so that together we may achieve a truly democratic society.

We will work to lift the standard of living and to improve our economic practices, so that you may have the material basis for a full life.

We will provide you with rewarding educational opportunities, so that you may develop your talents and contribute to a better world.

We will protect you against exploitation and undue hazards and help you grow in health and strength.

We will work to conserve and improve family life and, as needed, to provide foster care according to your inherent rights.

We will intensify our search for new knowledge in order to guide you more effectively as you develop your potentialities.

As you grow from child to youth to adult, establishing a family life of your own and accepting larger social responsibilities, we will work with you to improve conditions for all children and youth.

Aware that these promises to you cannot be fully met in a world at war, we ask you to join us in a firm dedication to the building of a world society based on freedom, justice, and mutual respect.

SO MAY YOU grow in joy, in faith in God and in man, and in those qualities of vision and of the spirit that will sustain us all and give us new hope for the future.

Midcentury White House Conference on Children and Youth

THE MIDCENTURY White House Conference on Children and Youth will stand out in the series of conferences dedicated to the young for the high degree and level of participation by young people themselves. Their presence did much to keep the discussions on a practical basis, and their comments were most stimulating. In one group where deliberations had become bogged down by technical terminology one of the young delegates spoke up and said, "Tell me what you mean and I will tell you what I think about all this." These young people had no hesitation in saying what they thought, and let us be thankful, for the youth of America are doing some pretty clear and straight thinking. These delegates in their teens and early twenties know full well they are growing up in a time of crisis. They are preparing for the worst and hoping for the best; they are interested in becoming a part of the world community through good citizenship.

The conference itself was splendidly organized. A good deal of the red tape of registration had been cut through preregistration correspondence and distribution of work material. The program was built around general sessions, panel discussion periods, and work groups. Although delegates were assigned to specific work groups, attendance at the general meetings and panels was voluntary. Generally, there was standing room only in most of the panel rooms, and the big auditorium began to fill at an early hour for each of the general meetings. The speakers deserved this earnest attention.

The Midcentury White House Conference, held in a momentous period of national and international crisis, was the largest of the five held during this century. Among the 5,500 delegates there were 250 international representatives from forty-one foreign countries. These visitors participated in the discussions but did not vote on the resolutions. There probably were more nurses in attendance than at the earlier conferences. This observer identified about seventy public health nurses, and there must have been many more nurses from all fields. Since each person finds in a conference of this kind information of special interest to herself and to her own community, it is well that so many nurses were present in Washington to carry back across the country the ideas to which they had been exposed.

A huge photomural on the stage facing the audience fitted well into the theme of the conference. The panel was lent by the United Automobile Workers-CIO. It pictures a group of children in whom the spirit of life is so strong that they seem to step right out of the picture. Their faces reflect the gamut of human emotions—joy, curiosity, shyness, friendliness, happiness, interest, insecurity, trust, concern, aggression, puzzlement, and wonder. It was a happy thought to borrow the panel.

Since this conference was concerned with the whole child it seemed fitting to start off with a consideration of the "spiritual foundations of our work with children and youth." Dr. G. A. Buttrick, pastor of the Madison Avenue Presbyterian Church, in New York, begged that we have faith in God as authority, as shelter, and as venture. "How else will our democracy endure? How otherwise can the crippling patterns of our present world be broken?" Such faith is best taught us by children, children full of wonder and trusting dependence.

Panel Highlights

The thirty-one panels presented a multitude of points of view, of facts and attitudes, all related to healthy personality development.

In many of these discussions the young people shared their ideas and told of their experiences "back home." They acknowledged conflicts in their own thinking and their need for help in finding their own places in the world. The panel materials added specific background data for many of the work groups. Of course, it was impossible for any one observer to cover more than a few of the panel sessions but some of the highlights which came out of these meetings are given here.

The meaning of citizen responsibility in our society

Citizenship begins the moment we acquire our first childhood impression. Therefore, in evaluating where we are in citizenship training—so that we may accurately determine where we are heading—it is essential that we ask ourselves the right questions—questions which may be quite painful but which must be answered none the less if an effective program is to be built. Parents must look at the home where the citizen-child takes on lifetime habits and attitudes; teachers must assess the role the school plays in shaping a young life; and all adults must survey the community environment and the effect it has on citizenship.

Parents interested in effective citizenship may well ask themselves: Is democracy practiced in our home? Does the whole family share in the making of important decisions? Do we demonstrate respect for the individual dignity and integrity of our children? Do we give their ideas the proper weight? Are they junior partners or submissive subjects?

It has been said that if we want to know what kind of citizens our children are most likely to become all we have to do is look at our communities. If children are taught one thing in the home and in the school and then bump into just the opposite thing out in the community they are going to ask questions. They are going to wonder why their parents and teachers haven't built the kind of community they profess to believe in. Why, our children ask, do not adult community deeds measure up to adult living room creeds?

In short, citizenship—to growing children—comes to mean pretty much what the community shows it to mean. If a community deprives its minority groups and its economically handicapped of equal educational opportunity or civil liberties or normal social development, then that community is setting the stage for bad, irresponsible citizenship. If the locality and the state and the nation each fails in its turn to take the steps—legislative and otherwise—necessary to correct economic and social injustices then our young citizens cannot be expected to act with maturity and resourcefulness.

—Earl James McGrath, United States Commissioner of Education, Federal Security Agency

The young must also be taught what it means to lose the freedom of choice. They should be taught what it means to live under a totalitarian society. . . . This does not mean the teaching of hate or the kind of violent nationalism which in the past has contributed to war. . . . The youth of America should learn what it means to live under totalitarianism in Soviet Russia and its satellites. With this teaching should go compassion for and understanding of the Russian people.

Young people should be made to understand what a comparatively new thing freedom of choice is in the world. Only with complete honesty and candor will we bring our young people to a realization that they are not the indifferent and privileged inheritors of two thousand years of struggle for freedom. Only with courage, imagination, and understanding can we bring them to accept true responsibility growing out of individual choice and to continue to carry on the desperate struggle to hold the bastion so narrowly won in the past.

—Marquis W. Childs

Dynamics of personality development

Personality development is influenced by heredity, early experience within the family, and the events of later life. Many of the adverse influences of early childhood can be corrected by later experiences in life. The ideal of maturity is never reached by most persons in complete form. In critical life

situations most people become insecure and seek help even before they have exhausted all their resources. Only self-assured, mature citizens can withstand in troubled times the aggressive urge to trade freedom for security obtained from some form of paternalistic government.

Self-governing, free democracies require greater mature independence from their citizens than does any form of socialism. The question then is how such emotional independence can be achieved—independence which can withstand the pressure of adversity. The child assumes responsibility for his own activities when his self-control is not based on fear of external authority but is rooted in his own conscience. The process of social adjustment in free democracies must be based on favoring the development of internal standards which become integral parts of the personality. This type of personality structure will develop only if the process of social adjustment is based on positive identification and love, trust, and the admiration of the growing child for those who are entrusted with his upbringing. The major problem of our time is to produce socially-minded, cooperative adults without sacrificing individuality.

—Franz Alexander, M.D., Director Institute of Psychoanalysis, Chicago

Influence of mobilization and war on children

The great adventure of children in the past two decades has been depression and war. There are three areas in which we can plan toward mitigating the bad effects of war on children: physical safety, education and health, and personality development. The effects of war on child personality depend on the remoteness of the war, whether the child has anxiety about his immediate family, and on the age, sex, personal integrity, and balance already achieved by the child.

The infant's welfare is tied up with that of the mother. A hurried, anxious, tense mother has a bad effect on the child, but even a grossly inadequate mother is likely to be better than a mother substitute. The child from three to six years of age may not be overly disturbed by the absence of the father during war unless the mother transmits her own fears to him. However, dependence solely on the mother during this period may tend to keep the child on an infantile level, especially with a boy learning appropriate masculine behavior. When the father returns it may be difficult to establish an emotional bond between father and child. School age children are better able to handle the effects of war. One difficulty is the likelihood that they may obtain a stereotyped picture of the absent father which conflicts with actuality when the father returns. The frustrations imposed on children as a result of war give rise to anxiety and aggression. Play can give release to the child, and the playing of war games should not be forbidden.

—Lois Meek Stolz, Stanford University

Effects of discrimination and prejudice on healthy personality development

Measured by any criteria children from minority groups face greater hazards and more handicaps to successful adjustment than children from majority groups. . . . The same potentialities for development exist in children of all races, groups, and religions. Prejudice and discrimination are contrary to the findings of scientific knowledge, inimical to the teachings of religion, and an obstacle to the workings of a democracy. Yet in our treatment of racial and religious problems what we do varies considerably from what we know. This discrepancy between what we know and what we do must be wiped out. Respect for others and wholesome acceptance of minority group members as individuals must be integrated into our very personality and must be a part of our daily living experience.

—Otto Klineberg, Columbia University

Preparation for marriage and parenthood in our society today

The parent who has not been understood in his own childhood cannot understand his mate and his children. He needs some belated understanding to supply what he has not had in his childhood. When this parent

seeks help for his children from the professional worker, the latter becomes a "belated" parent to him. Our first job in working with these parents is to understand that they are not "bad" because they have bad feelings of anxiety or fear or insecurity or ineffectiveness. Secondly, the professional worker in giving of himself as a belated parent should help in an "offering" way and not in a "stuffing down the throat" way. We must help parents, youth, and ourselves know that we don't have to feel guilty about lacks or problems. Every counselor or leader should be a part of a group with whose members he can discuss his own problems. Acceptance of "bad" feelings and the fact that all of us are human beings is most important to leaders.

—Dorothy Baruch Miller

Research in child development

Quite definite conclusions have been drawn about the specific psychiatric needs of infants and about the things which are beneficial to their development and the things that are harmful. Yet rarely has there been an opportunity to confirm these notions by direct observation of normally developing babies. We do not know for sure that breast feeding is more beneficial than bottle feeding; that a lot of demonstrated affection and not letting babies "cry it out" is better than a rigid schedule and impersonal care. We are willing to believe that warm, loving "mothering" is essential to the baby's welfare. But we don't know the details about the variety of ways in which such mothering can be offered to a baby. In a study under way at Menninger Foundation we are interested in finding factual support for currently accepted theories of development. If we fail to do so we hope to suggest modifications in our ideas which will better fit observable facts. We want to learn something about the concrete details of basic behavior.

—Sibylle Escalona
Menninger Foundation

Evaluating community mental health

Positive mental health is not primarily the concern of the psychiatrist. It is more the responsibility of those people in the community—such as parents, teachers, religious leaders, social workers, and nurses—whose activities bring them into contact with people in situations where guidance is possible.

—Rudolph G. Novick, M.D.
Illinois Society for Mental Hygiene

Recommendations

Although all the participants worked hard during the four and a half conference days the steering committee of the work groups truly did yeoman service. They burned the midnight oil preparing group findings and recommendations. These were then sent to the overall recommendations committee which combined and refined recommendations for presentation to the delegates at the final plenary session. There was nothing cut and dried about the reception given the recommendations. They were scrutinized, examined, reexamined, and debated. Some, especially in highly controversial areas, such as federal aid to education, religious training in the public schools, and racial segregation, were modified considerably. In general, the recommendations concerning further study of broad social problems, such as the causes of broken homes and the increase in divorces, slum clearance, et cetera, were accepted as presented. The recommendations growing out of the work of the section which considered "mobilizing citizens for the improvement of conditions affecting personality development of children and youth" are of special interest to us in the public health field. These included such recommendations as the following: "that professional workers should be trained in such a way that they will have an understanding and respect for other professional skills and contributors in order that they may work together to further community growth." (This sounds familiar to all who have thought of "team relationships.") Another held that "since citizen participation is essential for effective community services for children and youth, citizen advisory boards and similar groups representative of the community should be established for public services as well as private, and that every effort should be made to enable and secure participation by a cross section of the citizenry."

(This too rings a familiar note to public health workers.)

Space does not permit further detailed reporting of the recommendations. Since these will be referred to constantly in the next ten years they deserve our study. Single copies may be secured free of charge from the Midcentury White House Conference Committee, Federal Security Building, Washington 25, D. C. The proceedings of the conference will be published at a later date and we will print details of the report when it is available.

President Truman at the Tuesday morning session received a warm welcome. His talk was in a serious vein befitting the times we are passing through. He spoke of the crisis in world affairs which is affecting the lives of all young people.

The President said, "In the days ahead there will be many cases in which we will have to make special efforts to see that children get a fair chance at the right start in life. For as our defense effort is increased special problems will be created by the disruption of the lives of many families . . . . We must remember that we cannot insulate our children from the uncertainties of the world in which we live or from the impact of the problems that confront us all. What we can do—and what we must do—is to equip them to meet these problems, to do their part in the total effort, and to build up those inner resources of character which are the main strength of the American people."

Regardless of the fine work that went into the planning of the conference—and it was long and hard work—regardless of the earnest study and discussions carried out during the conference week, the Midcentury Conference would be only another meeting if it were not followed immediately by postconference activities. Fortunately, this has been part of the thinking throughout the preconference period and many of the local and state committees are geared to continue and are ready to take on the implementation of the recommendations in their respective localities. One of the chief purposes of the follow-up effort will be to disseminate the findings of the conference and stimulate action on the recommendations. It is expected that a national committee will be set up as an advisory and consultative group to work through all the groups which have a primary concern for the well-being of children and youth. In all these programs the participation of young people and the interdisciplinary approach which were demonstrated so well in the conference should be maintained and further developed. The interest in the follow-up programs indicates the sincerity of the conference participants in working with and for children and their future.

Leonard Mayo in one of his talks during the conference said, "Not only the well-being but the survival of coming generations depend on the emergence in these dark days of young men and women of stature. We [are] today in the shadow of a world crisis, but though disaster strike tomorrow we shall build for the long future." Our job lies clear before us.

American Journal of Nursing for February

An Administrator Discusses Public Health Nursing

CLARISSA GIBSON, R.N.

Public health nursing is creative

NOT LONG AGO ONE of our nurses stopped at a home where a cancer patient had suffered a lingering death. She found Mr. K., the patient's husband, sitting beside the bed dazed. There were no children or nearby relatives. The nurse helped to initiate funeral arrangements and after the funeral stopped at the apartment to see the man again. She knew that Mrs. K. had been the steadying force throughout the couple's long life together and that during her long illness the two had grown more dependent upon each other. Now Mr. K. was very much alone.

The nurse found that well intentioned neighbors were encouraging Mr. K. to give up his job as janitor, sell his belongings, and join his sister's family hundreds of miles away. Applicants for his job had already appeared. Mr. K. was anxious to talk to a "friend" and the nurse was a good listener. She learned he really wanted to keep his job but was confused by the advice showered on him. She helped him think through some of the practical problems. He had been doing most of the housekeeping for some time and could carry this on easily. Finally the nurse called the family clergyman who was ready to help the man during a time when he was faced with making many adjustments.

In taking this responsibility the nurse may well have prevented Mr. K. from joining the increasing number of foot-loose individuals we are finding among the elderly citizens. Her goals as a public health nurse well in mind, she was doing a creative job.

Miss Gibson is executive director, Visiting Nurse Association of Scranton and Lackawanna Counties, Scranton, Pennsylvania.

Can We Define Our Goals?

It is sometimes difficult for the young public health nurse and even for the more experienced one to define her goals amidst the confusing variety of appeals which are made to any family health service.

The variety of demands for service among which the nurse in the family health agency must define her area of work, struck me anew at week's end as I was setting my desk in order and arranging unfulfilled requests for early attention. Here were notations about our state legislative program for nurses, a letter from the community chest giving our allocation and suggesting a budget revision, and information to be assembled for a service club committee meeting. The chairman of our publicity committee wanted a conference with a professional member before starting her year-round program. One of our patients, a sick old man living alone and dependent on neighbors to prepare his food, is not getting enough to eat. The doctor says he is not a hospital case and he will not consider going to a county institution.

Among these demands and responsibilities can we define our personal sphere of work, formulate our individual and our agencies' goals, and direct our activities in a unified, constructive way? The statement, "Public

Health Nursing Responsibilities,"* affords a fine blueprint.

But in setting our goals we must be confident that we have a part, that it is more than running interference for others in the big game of public health. Sometimes we pass the ball but again we may be the ones who make the touchdowns. In our relationships with allied professional groups—social workers, psychiatric social workers, nutritionists, and teachers—we must assume our full share of responsibility for our part of the work and must define with these other professionals where our responsibilities dovetail with theirs as we serve our patients.

As nurses we are no longer considered a subsidiary profession (we were for years by our United States Government). To be sure, we carry out doctors' orders, but we have developed technics, accumulated a body of knowledge, acquired methods for teaching in homes and ways of motivating families to use medical and health knowledge. In my organization I occasionally remind one of our nurses that the Metropolitan Life Insurance Company has always relied upon nurses to decide how much care a patient needs, that nurses have established the policies for nursing care in the statewide medical assistance program.

The nurses of our state worked to have representation equal to that of the other professions on the Healing Arts Advisory Committee of the Department of Public Assistance. The policies for nursing care were formulated by our SNA Medical Care Committee through its representatives on the Advisory Committee. Now in each county the nurses' committee serves as adviser on all nursing policies and interprets the amount of nursing service needed to carry out the program.

We must assume such responsibilities if we are to bear our share of the load in medical care or health programs. And we must carry them not as isolated individuals but as members of the health team of doctor, family, and sometimes a social worker or a hospital.

The Lazy Way

Since nursing care in hospitals originally followed the lines of military authority and the nurse worked "under orders" she has sometimes taken the lazy way. She has become the willing helper to everyone instead of defining her own goals together with other workers on the team or even letting them know about the fine skills she has developed or the scientific knowledge she can put into action. When this happens we find an industrial nurse taking on secretarial work when she has no cut fingers to bandage rather than creating a health program within the industrial plant which could change the lives of the workers and give them a further joy in living.

Should it happen to a school nurse, she may become the recorder of school attendance, the cashier for the school lunch program, the chauffeur for the school principal. Her time is so taken up recording and writing out reports that she has little left for the creative part of her program. She cannot, for example, form a team of parents, children, and teacher which will afford the right climate for the child who has a health problem, as the child who has had rheumatic fever or the child with cerebral palsy.

When this happens to the nurse in the state health department she carries out all of the state regulations to the letter but does not bring creative interest to her work. When a tuberculosis patient does not return to clinic after the prescribed number of notices or home visits she discharges him instead of trying to discover the real reason for his indifference to his own welfare. This is a problem which requires the highest ability on the part of the nurse as she enlists the help of other members of the team in its solution. Understanding human behavior, adapting our technics to the needs of those we serve so they may better help themselves, is one of our most sacred trusts as public health nurses.

The visiting nurse who gives bedside nursing care in the home has a great opportunity to gain the confidence of the family, to impart scientific facts which will improve the

* National Organization for Public Health Nursing. Public health nursing responsibilities in a community health program. Reprinted from PUBLIC HEALTH NURSING, February 1949, v. 41, p. 67-69. 2 Park Avenue, New York 16, NOPHN, 1949. 3 p. Free.

health of every member. However, she may carry out the doctor's orders for treatment and make the person feel wonderfully comfortable but may fail to suggest, for example, that the correct posture of the patient in bed will aid her recovery, or to teach the basic foods, which when one is pennywise will improve family health, or to recognize that overconcern can be as harmful as giving the wrong medicine.

In this profession of ours how we act is as important as what we do. We love to be helpful and do just what people want us to do, foreseeing the doctor's or the patient's wants almost before they know they have them. Some in our profession can give this kind of service and at the same time keep their goals clear.

The Creative Way

What is the nurse's role? The nurse who helped the bereft husband find himself illustrates it, as does another who is assisting in a program to integrate social and health aspects of nursing into hospital care. This nurse who spends one and a half hours in a hospital three times a week recently visited in the ward a child with rheumatic fever who had become critically ill. The child's mother and father had been in an automobile accident and though recovering were unable to come to see her. The nurse arranged for volunteers to drive the mother in her wheel chair to the hospital to see her little girl, and the mother was able to be with her daughter from 10:00 A.M. to 4:00 P.M. In less than a week the child was off the critical list and the following week the physician, delighted with her progress, said she might be discharged. Then, of course, the child would be under the supervision of the public health nurse in the rural area in which she lived.

In one of our child health centers a nurse observed that a French warbride seemed unable to answer any questions about her baby. Her Polish sister-in-law stepped into the breach. In the home the mother-in-law dominated the situation. The nurse began to wonder whether this young Frenchwoman was mentally retarded, or had come from an isolated, rural district with no advantages, or was bewildered by the position to which she was relegated in the household. The nurse sought help from a volunteer who had been a French warbride following World War I. This volunteer, able to speak the young woman's language, arranged for her to attend Americanization classes. The young mother, freed from complete dependence upon her well intentioned in-laws, made friends and learned American ways with others who were strangers here. As her potentialities for motherhood were released the baby became happier. There is assurance now that the child-mother relationship will be a wholesome one and that this mother will guide her son in becoming a normal American boy.

How Does the Public Health Nurse Set Her Compass?

To be the confident and professional woman we are describing, able to carry her full share in the health program, the public health nurse must keep informed. She must be able to discriminate between scientific facts and what is hearsay or propaganda. She must know what is being said in popular health articles and on the radio. Our current professional journals give us the accepted scientific facts. Even during the last decade public health nursing services have been enriched by what we have learned from other fields; for example, nurse physical therapists. We are able to get people out of bed and walking earlier than ever before since we have made the principles of body mechanics a part of our everyday practices. By our ability to detect deviations from the normal in body mechanics we are able to add to the effectiveness of the whole orthopedic program in our community and state.

In the field of nutrition research workers are constantly adding to the store of knowledge and have proved a relationship between the good nutrition of the mother and the baby's well-being even to the extent of showing that stillbirths occur more frequently in a mother not well nourished. It is the up-to-date public health nurse who can interpret such simple facts as the use of skimmed dried milk for increasing the milk intake and the falseness of the idea that as people grow older they should take less protein in their diet.

Listen first

We have turned to other fields for help in developing our technics for working with people. We have learned that we are more successful when we do not tell people what to do but rather give them an opportunity to learn what is best for them to do in terms of their own felt needs. We must listen first in order to know what information or kind of help our patients are seeking. Some nurses with sensitivity and a lot of common sense have done fine work in mental health. The expansion in this whole field is resulting in a demand that nurses be better prepared in order to do their part in mental health services. The National Institute of Mental Health, USPHS, is providing funds for the preparation of public health nurses to become mental health nurse consultants. This consultant helps the generalized staff nurse to improve her understanding of emotional tensions in relation to disease, to detect at an early stage behavior changes which may suggest the need for psychiatric help, and to help release emotional tensions and promote wholesome relationships.

Isn't keeping pace with advances in medicine and in related health fields a big reason why public health nursing is always exciting —never monotonous? Young graduates come to my office and say, "I would rather be a public health nurse than do anything else." Then I say to this eager young graduate, "Are you willing to equip yourself to do this work?" Don't you think that perhaps it is because we, with all our faults, have done it so well—this keeping pace—that we are the group chosen to carry the latest health information to families? It is our ability to win the confidence of families and to motivate them to use the available resources which makes us so valuable in the health team.

Contributing to social planning

We must remember our job is not only to carry health messages to families but also to report their needs. We are the ones who learn what the family needs, how the family is affected by sociological conditions, by legislation, by high prices. We know whether the community, state, and federal resources are being made available in a practical way. Too often we have failed to give the doctor, the teacher, the clergyman, the social worker, the citizen, or the legislator our thoughtful opinion. We have an important role in social and health planning in the community. We should give our fellow teammates the benefit of our questions and our thinking as we join in conferences. In this role we participate in community activities, sitting together with representatives of other fields on legislative committees, planning how to meet cuts in department of public assistance grants, how to promote better adoption laws. Often we are the ones who can give the most convincing testimony as to why a fifty-five-year-old couple should not adopt a baby. We are contributors in the discussions here. Specialists in other fields will be the leaders.

Does She Keep Pace?

In public health nursing we are leaders. We face the future unafraid. We know that "public health is people," as Ethel L. Ginsburg has put it in the title of her recent book.† We know that the rigid rules under which some of us trained have been replaced by more flexible ones which offer an opportunity for good thinking. We know that some of our former practices have become obsolete. We no longer tell mothers to waken their babies regularly by the clock for feeding. We have replaced our detailed nursing of pneumonia patients by giving penicillin. We have found there are foods which are better sources of iron for the human body than spinach. And now we know there are psychosomatic illnesses!

Whether a patient with an infection is treated with penicillin or a young mother gets out of bed and walks when her baby is one day old, we know these apparent shortcuts have not lessened the public health nurse's responsibility. Like her sisters in the hospital she must be keener than ever to carry out her role effectively in 1951. It would be wrong for a nurse to use old methods. With

† Ginsburg, Ethel L. *Public Health Is People*. N. Y., Commonwealth Fund, 1950. 241 p. $1.75.

(Continued on page 90)

Progress in Structure Planning

The Joint Coordinating Committee on Structure has voted to make frequent reports to the memberships of all six organizations through the national nursing magazines, so that the members may keep informed of the committee's month-by-month work and give the committee the benefit of their opinions and suggestions before plans are in a final stage. This is the first of the committee's reports.

WHAT SHOULD BE the objectives of each of the organizations in the new nursing structure? How can the activities of each organization be mutually exclusive and yet closely coordinated? What machinery is needed to make coordination possible? Should the organization of new national sections precede the organization of state sections? Who should be members of the new Nursing League of America?

These are some of the questions that many nurses are asking as planning for the new two-organization structure for nursing moves steadily forward. Committees on structure for each of the six national nursing organizations* have been at work since the memberships approved a realignment into two organizations. Also, the Joint Coordinating Committee on Structure (composed of the chairmen of the committees on structure, the presidents, and the chief executives of the six national organizations) has met during September and November and will meet frequently throughout 1951.

Members of the joint committee have carefully reviewed suggestions forwarded to it by the individual organizations' committees. They are beginning to come to agreement on many points, which, for final decision, will depend on board action and on the opinions of the membership of the six national organizations.

Responsibilities of the Joint Coordinating Committee on Structure are: (1) to receive reports and recommendations from the separate organizations' committees on structure (2) to keep the committee on structure of each national organization informed of the deliberations and decisions of the Joint Coordinating Committee (3) to complete the design for the new structure and program for the two new organizations (4) to prepare guides and suggestions for state and district committees on structure (5) to encourage and guide experimentation in structure and joint activities (6) to ask states for reports on any plans for joint action that have been tried and found helpful.

Objectives of the Two New Organizations

As an important first step in planning for the new structure the Joint Coordinating Committee has tried to define the objectives of each of the two new organizations with such exactness that the distinction between them will be clear-cut and easily understood. The committee has agreed that the key words in determining the difference are *nurse practice* and *nursing services and education.*

Nurse practice is the responsibility of the

*The six national nursing organizations referred to are: American Association of Industrial Nurses, American Nurses' Association, Association of Collegiate Schools of Nursing, National Association of Colored Graduate Nurses, National League of Nursing Education, and National Organization for Public Health Nursing.

nurse as a practitioner. Nurses as members of a profession must establish professional standards of practice for the individual practitioner. It is essential that they promote effective counseling and qualified placement of the individual nurse, define her functions and qualifications, have a strong voice in legislation affecting her practice, look after her economic interests, and represent her in the International Council of Nurses. They can do this through an organization to which only professional nurses belong. The American Nurses' Association in the new structure would be this organization.

HOW TO ORDER REPRINTS

Help spread information on progress in structure planning by distributing reprints of this and future articles on structure. Place a standing order with PUBLIC HEALTH NURSING for reprints and see that they reach members of your staff and board or citizens committee.

On the other hand, the determination of community and institutional patterns and standards for nursing services and nursing education, and their promotion, organization, distribution, and financing are the responsibility not only of nurses but of the people themselves as supporters and consumers and of other professional and allied groups. To carry out this responsibility nurses in all fields and in all types of positions within these fields, members of governing boards of all kinds of community agencies concerned with nursing, members of the medical and other health professions, legislators, employers, educators, and users of nursing service should work together. All should play significant roles in determining the way in which organized nursing service should be provided to the people who need it and the ways of providing nurses with the education they must have to meet the needs of the people. The Nursing League of America (or whatever name is finally adopted, for this is only a tentative name) would be the organization dedicated to these purposes.

With these principles as a basis the Joint Coordinating Committee on Structure has tentatively outlined the objectives of the new American Nurses' Association (ANA) as: (1) defining functions and promoting professional standards of nurse practice in order to assure the highest standards of nursing service (2) promoting and protecting the economic welfare of nurses (3) actively promoting legislation and speaking for nurses in legislative action in general health and welfare programs (4) defining qualifications for the practitioner of nursing, including those in the various nursing specialties (5) providing professional counseling services for nurses and employers of nurses (6) serving as the official representative in the International Council of Nurses (7) determining the nurse resources of the nation, and (8) representing nurses and serving as their spokesman with allied professional and governmental groups and the public on a national and international basis.

The objectives of the new Nursing League of America (NLA) are as yet tentative. They have been provisionally outlined as: (1) promoting health in the community through the progressive development of nursing education and services, in cooperation with allied professional and citizen groups (2) defining and promoting aims and sound standards of nursing education (3) appraising and redirecting continually the content, organization, and administration of nursing education (4) appraising all nursing service in a community to promote the most effective methods of organization, administration, and utilization of personnel (5) providing consultant services to member agencies and to groups of members (6) cooperating with the ANA and allied groups in planning for legislation that affects nursing and health and in interpreting this legislation to its members (7) promoting the extension and proper distribution of organized nursing services throughout the country.

Joint Services

The question of whether the two new organizations should have joint services under a joint board of directors has received considerable attention from both the Committee

on Structure of the ANA and the Joint Coordinating Committee on Structure. It is the current opinion of the ANA committee that some of the joint services listed in the "1949 Handbook on the Structure of Organized Nursing"† might be the direct responsibility of either organization or of both. The ANA committee has also suggested that in the future structure there be a coordinating council instead of a joint board, as previously recommended. Such a council would not administer services but would coordinate the policies of both organizations in order to avoid duplication of effort. The joint committee has voted to ask the members of the six national organizations' structure committees to express their opinion of this suggestion.

Sections and Membership in the New ANA

The Committee on Structure of the ANA has suggested, and the Joint Coordinating Committee on Structure has tentatively agreed, that there should be seven sections in the new ANA. The joint committee is considering that these sections might be for these groups: private duty (or private practice) nurses, public health nurses, hospital general duty nurses, industrial nurses, hospital nursing service administrators, instructors and educational consultants, and unaffiliated.

The joint committee has also gone on record as believing that new sections should be organized in two steps: first, that a group organize as a conference unit in order to determine whether there is sufficient interest in setting up section machinery and to discover which members have potential leadership ability; next, that, if enough interest is demonstrated, the group organize with section status.

Functions of any section must, of course, be related to the objectives of the overall organization of which the section is a part. With that fact in mind the joint committee is tentatively recommending that the functions of sections in the ANA be:

1. Defining the qualifications for membership in the section and the qualifications for practice within that occupational field, including the preparation required for the several specialties within that field.
2. Studying the social and economic needs of the membership and developing desirable standards of employment. (Groups with like interests would have the privilege of meeting together as subunits of sections in order to consider the economic security program separately from other groups in the same section whose interests might be slightly different. For example, staff nurses or supervisors within a specific section might meet together as a unit for the purposes of the economic security program if they wished to do so.)
3. Establishing standards of practice and initiating studies or experiments for the improvement of practice within the field.
4. Representing the occupational interests in district, state, and national meetings.
5. Developing relationships with allied professional groups for conferences or committee work.
6. Conducting programs of special interest to the members of the occupational group or participating with other sections having similar interests.
7. Organizing conference groups for special interests within the section upon request.

These functions are substantially the same as those suggested by the ANA Committee on Structure at its October meeting.

The Joint Coordinating Committee on Structure is currently considering a recommendation that the organization of new state sections should precede the organization of new national sections. The ANA committee has recommended that when an occupational group comprises at least 5 percent of total state membership, then section status for the group should be considered. However, some members of the joint committee think that this may be too high a percentage and that numbers rather than a percentage should be used.

Both the ANA committee and the joint committee have questioned the recommendation made by previous structure committees that a graduate nurse become a member of the new ANA only through a section. Both committees suggest that a graduate nurse be

† Committee on the Structure of National Nursing Organizations. 1949 handbook on the structure of organized nursing. 40 p.

privileged to apply for membership in the new ANA before choosing section affiliation or to apply simultaneously for ANA and section membership.

Divisions and Membership in the New NLA

Membership in the new Nursing League of America should, in the opinion of the Joint Coordinating Committee on Structure, be open to all nurses who are ANA members. In addition, nonnurse citizens who are interested, community agencies, and schools should have the privilege of membership. Also, all individual members, as well as community agency and school representatives, should take part in the planning and decisions that are made within the entire organization. On this point both the Joint Coordinating Committee on Structure and the NLNE committee are at present in agreement. Both have also stated that there should be only two large divisions in the NLA, as outlined in the "1949 Handbook"‡—one on nursing service and the other on nursing education.

The Committee on Structure of the NLNE has, in addition, discussed the following matters relating to the new NLA: the advantage of organizing subgroups within each division to provide for the meeting together of individual members and representatives of agencies and schools who have like interests; the possibility of establishing a device (either through associate membership or through a subgroup of accredited schools which would make recommendations concerning the standards of accreditation) so that schools not professionally accredited will not lower standards; ways by which nonaccredited schools can be encouraged to progress to an accredited status; and the desirability of including nursing homes and convalescent homes, many of which are not registered by the American Medical Association, although consideration should be given to the registration or accreditation requirements of such organizations as the AMA.

The Committee on Structure of the NOPHN and the Committee on Structure of the NACGN met during December. The Committees on Structure of the ANA, AAIN, NLNE, and ACSN met before the board meetings in January.

‡ Committee on the Structure of National Nursing Organizations. Op. cit.

A Joint Board in States

The six national nursing organizations have found it expedient to work with a joint board§ during the present transitional period in order to facilitate joint action on all matters of common concern. Accordingly, the Joint Coordinating Committee on Structure is recommending that, while reorganization is pending, states having two or more state nursing organizations set up a joint board similar to the national plan, and that the first committee to be organized under this joint board be a joint committee on structure. The Joint Coordinating Committee is also recommending that a similar plan be made for districts so that all nursing organizations within the district will have equal voice and vote on the district structure committee.

A joint board of directors is not a legal entity, but a group of boards meeting together. It does not require new bylaws but may operate under rules it adopts. A joint committee under a joint board is different from a committee of one organization on which other organizations are represented. With a joint committee, the representatives of each organization report back to their own board and membership, and each organization's representatives have equal power in making decisions.

It is planned that each national organization will send a letter to its state constituents, explaining the details of this recommendation concerning a joint board and joint structure committees.

Opinions and Suggestions Are Requested

This report by no means includes all of the recommendations made by the national committees on structure. But it does include the major points. Further details will be reported frequently in the national nursing magazines.

§ A diagram of the Joint Board of Directors of the Six National Nursing Organizations appeared in the April 1950 issues of *The American Journal of Nursing* and PUBLIC HEALTH NURSING.

As previously emphasized, recommendations are very tentative. The Joint Coordinating Committee on Structure is eager to have comments and suggestions¶ from members of all six national nursing organizations as well as from other persons who are interested in seeing that the new structure of organized nursing is the best one possible both for the nurses of the country and for the persons with whom nurses work.

The Joint Coordinating Committee on Structure has one important suggestion in regard to comments on the realignment into two new organizations. It is that members of the six organizations carefully study the distinction between the two new organizations as outlined in the early part of this report. The committee believes that the success of the new structure may depend to a great extent upon widespread understanding of the purposes to which each organization is to be dedicated.

¶ All communications for the joint committee should be sent to the Joint Coordinating Committee on Structure, 5th floor, 2 Park Avenue, New York 16, N. Y.

An Administrator Discusses Public Health Nursing

(Continued from page 85)

her keen perception, her trained scientific skills, her flexibility in the face of new situations, and her understanding of people, she does not discharge a patient after his last hypodermic or when she sees him out of bed unless she is sure he is able to take the succeeding steps to resume normal activities.

We have always known that our success or failure have depended on our ability to work with people. That it is our skills in human relationships as well as in the concrete service we give which have made us so helpful in the forward advance in health.

Mrs. Ginsburg reminds us that we have been excessively dependent upon the physician in the past and probably will be for some time. "This dependency," she states, "tends to invest the doctor with a degree of omniscience that he could not possibly have, while at the same time it tends to be critical of normal vacillation or change. . . . In several different ways health officers were saying that their security is threatened by the dependency of the nursing group. . . . They expect you to make up your mind and then not deviate." They don't want us to think they have all the right answers but rather think and experiment with them. I believe it was this kind of ability which brought recognition to Marion Sheahan when she was chosen for the Lasker Award in 1949.

"But," continues Mrs. Ginsburg, "there seemed to be a general acceptance of the fact that more recent training for nurses emphasizes flexibility and that group-for-group, in the public health field today, the nurses are far in advance of other disciplines and much more ready to accept newer methods and philosophy."

We public health nurses can face the future unafraid, with a steadiness of purpose, flexibility in our thinking, open minds ready to embrace new problems and to bring to them our most critical thinking from a storehouse of scientific knowledge, and above all with the awareness that "public health is people" with all their pesky and loving ways. It is our privilege to serve them in a unique way.

This article is based on a paper presented at an Institute on Family Health Services sponsored by the Lancaster County Public Health Nurses Organization, Lancaster, Pennsylvania, on April 20, 1950.

Venereal Disease Programs in European Countries

HAZEL SHORTAL, R.N.

IN REPORTING ON a trip to Europe one is tempted to speak of the beautiful scenery, the places of historical interest, and, particularly, the abundant hospitality of the people in the countries visited. But since the purpose of this paper is to describe some impressions of European venereal disease control programs, those very pleasant aspects of the trip can only be noted in passing.

On the trip, in the summer of 1949 Sweden, Denmark, Switzerland, Italy, England, and France were visited. Each of these countries reported that venereal disease incidence since the war has dropped back to approximately the prewar level.

Since the time spent in each country was brief the observations on which these remarks are based were necessarily cursory. However, a few impressions gained from these short visits appear to have rather general application. For one thing, clinic attendance was good. This regularity was apparently the result of widely varying factors. In some places, for example, it was due to the atmosphere of the clinics, in others to the effective use of police authority. Another matter of interest—frequently observed by visitors from the United States—is the extensive use of arsenicals and heavy metals in the treatment of syphilis. Some of the countries are undertaking casefinding through investigation of sex contacts. In this they are apparently placing chief emphasis on "source contacts," that is, persons from whom diagnosed venereal disease patients have presumably acquired infection. Mass serology and public venereal disease education are not included in any of the control programs observed.

Miss Shortal is chief nursing consultant, Division of Venereal Disease, Public Health Service, Federal Security Agency.

Sweden

In Sweden every person with a venereal disease in an infectious stage is required by law to undergo treatment until he is certified by his physician to be healthy. Reporting of cases is compulsory. Knowingly to expose another person to venereal infection is punishable by up to two years of penal servitude. No person with a venereal disease in an infectious stage is permitted to contract marriage without the consent of the state.

Treatment is provided by private practitioners, local health officers, and in outpatient clinics. In the clinics observed, patients were usually treated with penicillin, followed by a series of arsenic and bismuth injections. Treatment for venereal disease is free in both hospitals and clinics, and the cost is borne by the appropriate local government authority.

There is apparently little difficulty in holding patients to treatment. Patients who fail to respond to letters from the health authority are readily located by the police through the national registration. Physicians who diagnose venereal disease in an infectious stage interview their patients for contacts and then refer them to a "curator," a nurse with social work training, for further interviewing. Field investigations are then initiated by the curator.

Although there is no antepartal blood test-

ing law a number of maternal welfare centers regularly perform blood tests for syphilis.

Denmark

Danish laws and regulations respecting venereal disease are generally similar to those of Sweden. As in the latter country, case-holding is chiefly conducted through correspondence, supported by police assistance when necessary. Food ration registration files are utilized to supply current addresses of persons who lapse from treatment, if old addresses prove to be inaccurate. Both contact-interviewing and investigation are placed largely in the hands of social workers.

Treatment in the clinics observed consisted of penicillin combined with arsenic and bismuth. In one clinic a study was in progress of syphilis therapy employing penicillin in one of the newer absorption-delaying vehicles, without subsequent arsenicals and bismuth.

Since 1945 free examination of blood specimens of pregnant women has been provided through the State Serum Institute. In 1948 only forty-five cases of congenital syphilis were reported in Denmark.

Switzerland

Each of the twenty-four cantons of Switzerland functions independently in health matters. Venereal disease reporting is not compulsory and overall statistics on these infections are not available. Venereal disease is not considered a major health problem.

Treatment for venereal disease in Switzerland is usually provided in the offices of private physicians, since 90 percent of Swiss citizens have sickness insurance which includes venereal disease treatment. Considerable skepticism was voiced by physicians interviewed respecting the efficacy of penicillin alone in syphilotherapy, and in all the clinics visited arsenic and bismuth were given after penicillin.

Responsibility for casefinding rests with the agency which diagnoses the case. In the clinics conducted by the university some of the interviewing is done by assistant professors, some by social workers, and some by the *assistante sociale,* whose functions are much like those of the public health nurse in our own country. Field visits are made by the *assistante sociale.*

Italy

Because venereal disease reporting is not compulsory in Italy the extent of the problem is difficult even to estimate. During 1947 about 45,000 cases of syphilis and 46,000 cases of gonorrhea were seen in the dispensaries. Penicillin, which is very limited in supply, is generally reserved for treatment of conditions other than venereal disease.

Probably the outstanding health service in Italy is the National Office for Maternal and Infant Welfare, known as ONMI. Established during Mussolini's regime, this service provides not only clinic services but also day care for children. Pregnant women in the lower income groups are given their noonday meal at the centers from the time they are six months' pregnant until nine months after the baby's birth in an effort to maintain breast feedings. At the time she reports for maternal hygiene supervision every pregnant woman is given a blood test which is repeated later in pregnancy if indicated. Children born of syphilitic mothers are tested serologically at stated intervals during the first two years of life.

Some penicillin was made available to the centers in 1949 though the United Nations International Children's Emergency Fund, and a larger supply of antibiotic was expected in 1950. Patients not treated with penicillin were given arsenic and bismuth.

France

The chief of the French Ministry of Health expressed the belief that in his country the decline in venereal disease incidence to pre-war levels was attributable to stabilization of the population rather than to new developments in treatment.

Physicians inerviewed seemed to feel that penicillin may be useful as a means of "controlling contagion" in syphilis, or that the drug may have some therapeutic effect when used in conjunction with bismuth. To rely exclusively on penicillin seemed to them unwise.

Venereal disease reporting in France is

compulsory. The chief of the Division of Venereal Disease, Ministry of Health, stated that few patients in France are treated for venereal disease by private physicians and that, consequently, the small number of cases reported by these physicians is fairly representative. On the official report form, space is provided for identification of a single contact, and epidemiological procedures are instituted by health authorities at the request of the physician.

In Paris most venereal disease treatment is given in hospital dispensaries and in dispensaries operated by La Caisse Centrale d'Allocations Familiales de la Region Parisiene (Health Department Clinic). Special *assistantes sociales* are assigned to venereal disease work in the capital city, while in rural areas the *assistantes sociales* include venereal disease duties as a part of their family health service program.

England

Under the National Health Service administrative responsibility for venereal disease work is assigned to regional hospital boards, which function apart from regional and local offices concerned with preventable disease activities. In some instances the county councils continue to designate almoners (social workers) or health visitors (public health nurses) to perform casefinding and caseholding duties in venereal disease clinics located in hospitals.

Clinics in London are open from 9 A.M. to 9 P.M. Those visited were not crowded, and patients were seen without delay. The atmosphere of dignity which prevails in the clinics and the privacy which is afforded to patients are believed to account for the small number of lapses from treatment. In at least three of the clinics visited penicillin alone was administered for early syphilis. In some treatment centers courses of arsenic and bismuth were given after penicillin for latent syphilis.

Throughout England patients who know their contacts are expected to bring them to the clinic or to arrange for clinic attendance. The confidential nature of venereal disease work is strongly emphasized, and patients are known to clinic personnel by number only. Identifying information is given to a clinic staff member only when a patient lapses from treatment and a home visit becomes necessary.

Though variations in approaches to patient care were noted in each country visited, according to established patterns of health work, enthusiasm and keen interest in the eradication of venereal disease were manifest everywhere.

Breast Self-Examination

(Continued from page 75)

lic Health Service. Cancer of the breast. 47 Beaver Street, N. Y. 4, American Cancer Society, Inc., 1949, 20 p. Free from local divisions of the society.

Saltzstein, Harry C., and Robert S. Pollack. Benign tumors of the breast. *The Journal of the American Medical Association*, July 23, 1949, v. 140, p. 997-1001.

Smith, Genevieve W. When a breast must be removed. *The American Journal of Nursing*, June 1950, v. 50, p. 335-339.

Sugarbaker, Everett D., and Lucy E. Wilfley. Cancer of the breast. *The American Journal of Nursing*, June 1950, v. 50, p. 332-335.

Community Health Survey

ELSIE MAXWELL HAMM, R.N.

DONE A SURVEY lately? We have in Tillman County, Oklahoma, and we think we have something new. That something is a homemade schedule, a "Survey of Public Health Problems, Facilities and Services," which was given its initial trial in our county and proved so effective in awakening citizens to their need for a fulltime county health department that we feel it should be shared with communities everywhere and especially with those which still are on the "frontiers of public health."[1]

A health survey of some sort seems to be a necessary first step in the planning of effective community health work and in enlisting the interest of the people served.[2] But a nurse starting out in a new area or a citizen committee trying to determine health needs in preparation for service usually finds the available survey forms too comprehensive, too detailed, or too time-consuming. Counties which have not had public health services usually do not have extensive health records and, therefore, many items on a lengthy survey form must remain incomplete for lack of information. This in itself is frustrating, but, in addition, most surveys are too complicated for lay people to handle so that they have to call upon professional help to complete their studies. The survey schedule used in Tillman County was designed for ready use by the layman.

What has been happening in Tillman County has been happening in many places throughout the country. Communities that never have enjoyed the benefits of a fulltime health department are becoming aware of their needs. Public health services have to start from scratch, and usually the first spark of interest comes from some small group within the community that asks, "Why can't we have a fulltime health department like they have in ——— County?"

Representatives from the state health department come to town and meet with the interested citizens. Questions are answered and others are asked. Meetings are arranged, discussions are held, and films are shown presenting the benefits of a fulltime local health service. A logical suggestion is made that a community group undertake a survey to determine specific health needs and problems. This suggestion can be carried out if a simple survey form is available and if plans can be made so that the survey activity will not be too time-consuming.

The survey schedule used in Tillman County was developed by Dr. J. W. Shackelford, director, Local Health Service, Oklahoma State Department of Health, and Miss Margaret Chapman of his staff. It is adapted from the more inclusive "Evaluation Schedule" of the American Public Health Association and is written in a simple question and answer form.*

What the Survey Showed

Upon completion the community survey gives a true picture of health needs. Let us see what it showed about Tillman County.

We found we had an area of 865 square miles with a population of 19,989 (17,563

Mrs. Hamm is at present not actively engaged in nursing. She assisted with the survey in Tillman County as an interested citizen.

** Copies of the schedule have been made available to* NOPHN *for loan purposes. To borrow a copy, write* NOPHN, *2 Park Avenue, New York 16, N. Y.*

white and 2,426 non-white), 7 towns but an urban population of only 7,500. There was a definite shortage of professional personnel in private practice but the county showed an assessed valuation clearly indicating that the community could afford more private service as well as a fulltime county health department.

There was a lack of local publicly supported professional services for children with handicapping conditions.

The county's ten leading causes of death closely paralleled those for the nation at large. No local programs of study, education, or service had been undertaken to combat or lessen the leading causes of death.

Answers to questions on community organization showed that there were an active tuberculosis association and four civic clubs which had committees on health and welfare and were interested in health problems. But there was no citizen group, such as a health council, that could coordinate the planning and support from all these groups for the improvement of health problems.

In regard to communicable disease control it was found that immunizations were available only from private physicians and that there had not been any immunization program in eighteen years. Statistics showed that in the past five years there had been five deaths from diphtheria. Surprising, isn't it, that there were not more?

According to state records (the county had no tuberculosis register or records) there were thirty known cases of tuberculosis, and seven new cases had developed during the preceding year. However, no one in the county was doing fulltime casefinding or follow-up on patients and contacts.

In venereal disease control, the state-aid program had assisted the county greatly in casefinding, rapid treatment, and follow-up. Venereal disease control was not an outstanding public health problem here.

Maternal health was an entirely different matter. The county had a substantially higher maternal death rate (3.5) than the state of Oklahoma(1.8) or the nation at large (1.9) for the years 1943-48 inclusive. Many Negro and white mothers of the tenant farmer group were never seen by a doctor before, during, or after childbirth, and this undoubtedly influenced the death rates for both mothers and babies.

If the infant death rate of a community can be used as a fairly reliable index of the general health of that community (as some health authorities suggest) then Tillman County certainly needed health service. The average infant death rate for the years 1943-48 inclusive was 41.0 as compared to 35.6 for the state of Oklahoma and 36.5 for the nation at large.[3] These figures together with the maternal death rate statistics were very effective publicity material.

Similarly, if any one group showed an outstanding need for service, it was the children of school age. No health examinations were offered or required before or during school life; no vision or hearing tests were given. As mentioned above, immunizations were available only from private physicians and were not required for school entrance. The school authorities were anxious for health service and were quick to provide in the school budgets for a contribution to the financial support of a health unit.

In accident prevention Frederick, the county seat, probably fared as well as most towns and better than some. Two highway patrolmen were stationed there, and they in cooperation with the Oklahoma Safety Council conducted a safety program. Frederick was given an award for having no traffic fatalities during the year 1949. Still, accidents remained the fifth leading cause of death for the county as a whole and it seemed that much work remained to be done.

In the investigation of water supplies and excreta disposal facilities, one town in the county was found lacking an approved water supply. Two towns had questionable sewerage disposal facilities.

Food and milk control were interesting studies because there was a complete lack of food ordinances in the entire county and only one outdated milk ordinance was in effect. There had been some dramatic demonstrations of the need for such control. One small town (population 1,200) had in the recent past an outbreak of 109 cases of food

poisoning traced to unrefrigerated cream pastry. Three weeks later there were 79 cases of septic sore throat in the same town traced to a raw milk supply.

In regard to financial support it seemed evident that, with the state aid available, the school districts, the city of Frederick, and Tillman County could support a fulltime county health unit.

The Health Council

Forming a County Health Council to work on the project was the next step. A popular, energetic, and well informed young businessman was elected president. He arranged for programs to be given to civic clubs and other groups all over the county. Tillman County abounds in organizations and one can reach almost every person in the county if one can hold out long enough to attend all the meetings.

The County Health Council had the support of a friendly press and local radio station. The survey was used as subject matter for the talks and programs and provided material for a series of editorials entitled "Why Tillman County Needs a Health Unit," which ran in the daily press.

After the publicity campaign the Health Council president appeared before the Frederick City Council and asked the city to contribute its share for the financial support of a county health unit. He was given full cooperation and the city officials voted to allocate Frederick's share of the money. Later when the program was outlined to the county commissioners and its value to the public explained, the commissioners agreed to provide for the county health department in the 1950-51 budget. The latest and one of the most gratifying developments of the whole campaign was the approval by the regional office of the American National Red Cross for a contribution of $2,500 from Tillman County Chapter for office equipment for the new county health department.

The Health Council feels that its work has just begun. Organized on a permanent basis, it is ready to go ahead and assist in the work of a county health department.

Check off one more county with fulltime local public health service! What could an interested civic group and a community health survey do for some county you know that is still struggling behind the scenes, needing to be brought out front and center in the full glare of the spotlight for everyone to have a good look at its attributes and shortcomings. Especially the shortcomings! If there are many outstanding health needs the discovery is not a reflection on any one person or organization but on the community as a whole. And "letting the people know" is still the best way of getting things accomplished in a democracy.

REFERENCES

[1] Parran, Thomas. Spearhead of public health. PUBLIC HEALTH NURSING, December 1949, v. 41, p. 631.

[2] Hiscock, Ira V. *Community Health Organization.* 3rd ed. N. Y., Commonwealth Fund, 1939. (Page 280.)

[3] Federal Security Agency, Public Health Service, National Office of Vital Statistics. Vital statistics—special reports, National summaries: vol. 27, No. 12, December 31, 1947, Infant mortality from selected causes by age, race, and sex, United States, 1945; and vol. 31, no. 14, September 22, 1949, Infant mortality from selected causes by age, race, and sex, United States, 1947.

Regional Conferences

Please note: Just as we go to press we find it necessary to change the dates of the NOPHN Regional Conference to be held in Portland, Oregon. The new dates are May 16-18. Please put this information on your calendar.

Completion of an Educational Program in Nursing Approved for Public Health Nursing

An Interpretation by the Education Committee of NOPHN

WHEN "RECOMMENDED Qualifications for Public Health Nursing Personnel, 1940-45" was published in 1942 by the NOPHN,[1] it contained the following statement: ". . . completion of the year's study in public health nursing in a university program approved by the NOPHN." Since that date other official publications of the NOPHN have contained statements regarding qualifications of public health nurses which referred to "completion of an approved program of study in public health nursing." (See references 2 through 7.)

Practices in public health nursing education make it necessary to amplify and interpret the meaning of these statements for the following reasons:

1. Several universities have developed educational programs for the preparation of public health nurses that extend beyond the minimum of "one academic year plus a summer session," as stated in "Essential Requirements for Programs of Study in Public Health Nursing for Graduate Nurses Preparing for First Level Staff Nurse Positions."[8] Many universities have ceased looking upon the "year's preparation" as a separate unit and instead offer graduate nurses a program leading to a degree with a major in public health nursing. For such a major many important prerequisites have been set up, and a sequence of study is planned so that the student gains an increasingly broader and deeper understanding of her professional responsibilities. Recognition by the university is given only upon completion of the degree requirements and a period of a "year's study" does not cover the content outlined.

2. The length of time required for completion of any educational program is influenced by such factors as admission requirements of the university, prerequisites for professional courses, and the previous education and professional experience of the individual student.

3. All required professional courses may not be offered during every semester or quarter or session of university instruction. This may be due to lack of instructional personnel, small enrollments, and dependency upon departments of the university other than nursing for certain service courses such as nutrition and mental hygiene.

4. Ten or twelve consecutive months of university instruction may not always be offered because of the semester system observed by many universities.

5. The traditional "one year's" program of study in public health nursing is not readily identifiable in approved collegiate basic nursing programs preparing nurses for public health nurse positions under supervision in public health nursing services. Essential professional content is integrated throughout clinical instruction and other courses and is correlated with the total planned learning experiences included in the program.

6. Nurses who have set aside a year for educational purposes have found that they are unable to complete the requirements of an educational program in public health nursing within that period of time. A nurse might conceivably spend an academic year or even a calendar year in a university and not complete the requirements of that university in some important aspect of public health nurs-

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ing theory or field instruction. This is particularly true if in that year the nurse must pursue courses such as those designed to develop communication skills, psychology, and sociology, which are sometimes prerequisite to required professional courses in the public health nursing major.

7. Agencies have released nurses for a year of study and stipends have been granted for that purpose, only to find that there still are educational lacks in the nurse's preparation for public health nursing.

It is now recommended by the NOPHN Education Committee that:

> **The phrase "completion of an educational program in nursing approved for public health nursing by the National Nursing Accrediting Service" be used to describe the recommended professional preparation for public health nursing, and that**
>
> **The university with an approved program be considered the appropriate authority to state whether a nurse has completed the requirements of an educational program designed to prepare her for public health nursing positions.**

TODAY THERE ARE two categories of educational programs preparing nurses for beginning public health nurse positions in public health nursing services. Programs in both categories are approved for public health nursing by the National Nursing Accrediting Service. Prior to November 1949 these programs were reviewed for approval by the NOPHN.[9, 10]

Nurses who have completed either of these programs meet the NOPHN recommended qualification for "completion of an approved educational program in public health nursing." These two categories are:

1. A collegiate basic nursing program leading to a degree. Some of these programs offer integrated programs and some function on a senior college level or as graduate schools. A nurse who has completed such a program is prepared for beginning public health nurse positions under supervision in a public health nursing service.

2. A program for graduate nurses leading to a baccalaureate or higher degree with a major in public health nursing. This is a well organized program conducted by a college or university. A nurse who has completed such a program is prepared for beginning public health nurse positions in a public health nursing service.

Although there are variations in admission requirements, length, and total content of these programs according to their purposes and the particular university or college which administers them, they all meet specific criteria for educational programs in public health nursing established by the NOPHN.[7, 8] There is no common denominator in terms of months, quarters, semesters, academic year, calendar year, course titles, et cetera. Each educational pattern for the preparation of public health nurses expresses the individuality of the university or college administering such educational programs. However, essential theoretical and practical instruction based upon the *Public Health Nursing Curriculum Guide*[11] is included in any program approved for public health nursing by the National Nursing Accrediting Service.

THE TYPES OF RECOGNITION given to students who have completed an educational program for preparation for public health nursing differ in various universities.

1. In some universities recognition is not given until the student has completed all of the requirements for the degree, including those phases of the program that are essential for public health nursing preparation. At this time a degree is granted. A few universities award a degree and a certificate in public health nursing simultaneously. The degree may or may not indicate the major field of preparation. It may be a bachelor of science, a bachelor of nursing, a public health nursing degree, or other degrees consistent with practice in a particular university.

2. Other universities permit their students to complete the professional portion of the program, that is, the public health nursing major, before completion of the total degree requirements. In this instance the university may give the student a statement testifying to the work that has been completed. Occasionally a certificate in public health nursing may be granted for this purpose. In some

cases no formal recognition is given.

It is obvious in the light of these varying practices that the university in which a nurse secures her preparation is the only authority competent to state whether she has completed that university's requirements for preparation in public health nursing.

Universities routinely engage in the practice of reviewing transcripts from other universities when evaluating the professional credentials of nurses who have had previous university instruction and wish to enroll in some phase of public health nursing education. Through this practice appropriate transfer credit may be given, deficiencies in essential content areas in public health nursing may be noted, and supplementary instruction may be recommended and provided as needed. Usually, universities conducting approved educational programs in public health nursing do not grant transfer credit for required professional courses in the public health nursing major unless the content has been secured in an approved program in public health nursing in another university. It is suggested that:

1. The *prospective employer* of public health nursing personnel, placement services, and state certificating agencies should clear with the appropriate university to determine whether a nurse applicant for a position has completed an approved educational program that prepares her for a position in public health nursing.

2. *A nurse* who is seeking employment in public health nursing should be able to present credentials that show evidence that she has completed an approved educational program in nursing for preparation in public health nursing.

3. *A prospective student* who is planning to enter a university or college offering an educational program approved for public health nursing will be able to find out through correspondence and by submitting credentials and an application for admission how long it will take her to complete the requirements of that particular university.

REFERENCES

[1] National Organization for Public Health Nursing. Recommended qualifications for public health nursing personnel, 1940-45. (PUBLIC HEALTH NURSING, January 1942, v. 34, p. 24-28); and Recommended qualifications: an interim report by the Committee for Revision. (PUBLIC HEALTH NURSING, May 1948, v. 40, p. 261-262.) Available in one reprint from NOPHN, 2 Park Avenue, New York 16. Free.

[2] ———. Nurse mental health consultant: functions and qualifications. PUBLIC HEALTH NURSING, September 1950, v. 42, p. 507-509. Available in reprint form from NOPHN, 2 Park Avenue, New York 16. Free.

[3] ———. Nurse in the school health program. PUBLIC HEALTH NURSING, August 1949, v. 41, p. 438-441. Available in reprint form from NOPHN, 2 Park Avenue, New York 16. 10 cents.

[4] Joint Orthopedic Nursing Advisory Service. Nurse in the orthopedic field. Pamphlet. A revised issue will be available soon from JONAS, 2 Park Avenue, New York 16. Free.

[5] National Organization for Public Health Nursing. Recommended qualifications for public health nursing faculty and teaching personnel. To be published in PUBLIC HEALTH NURSING. Will be available in reprint form from NOPHN, 2 Park Avenue, New York 16. Free.

[6] ———. NOPHN recommended salaries for public health nurses, 1948. PUBLIC HEALTH NURSING, April 1949, v. 41, p. 200-203. Available in reprint form from NOPHN, 2 Park Avenue, New York 16. Free.

[7] ———. Criteria for collegiate basic professional programs designed to prepare their graduates for first level positions in public health nursing under supervision.* Available in mimeographed form from NOPHN, 2 Park Avenue, New York 16. Free.

[8] ———. Essential requirements for programs of study in public health nursing for graduate nurses preparing for first level staff nurse positions.* Available in mimeographed form from NOPHN, 2 Park Avenue, New York 16. Free.

[9] ———. Educational programs for the preparation of public health nurses. Published periodically in PUBLIC HEALTH NURSING. Available in reprint form from NOPHN, 2 Park Avenue, New York 16, Free.

[10] National Nursing Accrediting Service. Educational programs in nursing approved by the National Nursing Accrediting Service—1950. *The American Journal of Nursing*, February 1950, v. 50, p. 114-116. Available in reprint form from the NNAS, 2 Park Avenue, New York 16. Free.

[11] Joint Committee of the National Ogranization for Public Health Nursing and the United States Public Health Service. *Public Health Nursing Curriculum Guide*. N. Y., NOPHN, 1942. 206 p. $2.

* Published in:

National Nursing Accrediting Service. *Manual of Accrediting Educational Programs in Nursing*. 2 Park Avenue, N. Y. 16, NNAS, 1949. 114 p. $4. See: Criteria for evaluation of programs of study in public health nursing, p. 85-98.

EDUCATIONAL PROGRAMS FOR THE PREPARATION OF PUBLIC HEALTH NURSES

Thirty-eight colleges and universities offer approved programs of study for the preparation of public health nurses.

The thirty-five colleges and universities listed below offer educational programs for graduate nurses leading to a degree. These programs prepare students for beginning public health nurse positions in public health nursing services. While the objectives are different, with resulting variations in admission requirements, length, and content, all programs meet the essential requirements of the National Organization for Public Health Nursing in theoretical and practical instruction, and are approved for public health nursing by the National Nursing Accrediting Service.

For further information write directly to the appropriate educational unit in nursing in the college or university, addressing the person indicated below.

University or college and location	Address inquiries to:	Public health nurse faculty member in charge of program	Year of approval of program[a]
The Catholic University of America School of Nursing Washington 17, D. C.	Lucille E. Corcoran, Acting Director Division of Public Health Nursing	Lucille E. Corcoran	1926
Columbia University Teachers College, Division of Nursing Education New York 27, N. Y.	Admissions Office Teachers College	Lillian A. Hudson Professor of Nursing Education	1920
Duquesne University School of Nursing 811 Bluff Street Pittsburgh 19, Pennsylvania	Grace Frauens, Director Public Health Nursing Program	Grace Frauens	1938
George Peabody College for Teachers Division of Public Health Nursing Education Nashville 4, Tennessee	Edna Lewis, Director Public Health Nursing Education	Edna Lewis	1921
Incarnate Word College Department of Nursing Education 4301 Broadway San Antonio, Texas	Catherine M. McDermott, Director Program of Study in Public Health Nursing	Catherine M. McDermott	1943
Indiana University School of Education Division of Nursing Education Bloomington, Indiana	Lucy C. Perry Assistant Professor of Public Health Nursing	Lucy C. Perry	1939
Loyola University School of Nursing 820 North Michigan Avenue Chicago 11, Illinois	Essie Anglum, Chairman Department of Public Health Nursing	Essie Anglum	1941

[a] From 1920 through 1941 approval was considered retroactive for the two-year period prior to year of official action.

University or college and location	Address inquiries to:	Public health nurse faculty member in charge of program	Year of approval of program[a]
Marquette University College of Nursing 3058 North 51 Street Milwaukee 10, Wisconsin	Sister M. Thomas, O.S.F. Dean, College of Nursing	Anna Hassels, Director Public Health Nursing Program of Study	1940
Medical College of Virginia[b] School of Nursing 1220 East Broad Street Richmond, Virginia	C. Viola Hahn, Director Program of Study in Public Health Nursing	C. Viola Hahn	1937[b] 1943[b]
New York University Department of Nurse Education 49 South Building Washington Square New York 3, New York	Blanche L. George, Director Programs in Public Health Nursing	Blanche L. George	1938
North Carolina College at Durham Department of Public Health Nursing Durham, North Carolina	Mrs. Esther Henry Benjamin, Director Department of Public Health Nursing	Mrs. Esther Henry Benjamin	1949
St. John's University School of Nursing Education 303 Washington Street Brooklyn 1, New York	Mary C. Mulvany, Dean School of Nursing Education	Mary C. Mulvany	1940
St. Louis University School of Nursing 1402 South Grand Boulevard St. Louis 4, Missouri	Sister Mary Geraldine, S.S.M. Dean, School of Nursing	Lucille C. Becker Instructor in Public Health Nursing	1938
Seton Hall University School of Nursing 40 Clinton Street Newark, N. J.	Eleanor W. Mumford, Director Program of Study in Public Health Nursing	Eleanor W. Mumford	1942
Simmons College School of Nursing 300 The Fenway Boston 15, Massachusetts	Marjory Stimson Professor of Public Health Nursing	Marjory Stimson	1920
State University of New York Medical Center at Syracuse University, College of Medicine Department of Public Health Nursing 766 Irving Avenue Syracuse, New York	Margaret L. Shetland, Director Department of Public Health Nursing	Margaret L. Shetland	1932

[a] From 1920 through 1941 approval was considered retroactive for the two-year period prior to year of official action.
[b] Two programs are offered: one, approved in 1937, for Negro students, the other, approved in 1943, for white students.

University or college and location	Address inquiries to:	Public health nurse faculty member in charge of program	Year of approval of program[a]
University of Buffalo School of Nursing 25 Niagara Square Buffalo 16, New York	Mrs. Anne W. Sengbusch Dean, School of Nursing	Elizabeth M. Hanson Administrator, Public Health Nursing Program	1941[c]
University of California School of Nursing Berkeley, California	Margaret A. Tracy Dean, School of Nursing	Amy A. MacOwan Assistant Professor of Public Health Nursing	1920
University of California School of Nursing 405 Hilgard Avenue Los Angeles 24, California	Lulu K. Wolf, Dean School of Nursing	Agnes A. O'Leary Assistant Professor of Public Health Nursing	1940
University of Chicago Department of Nursing Education 5733 University Avenue Chicago 37, Illinois	Mary M. Dunlap Associate Professor of Nursing Education	Mary M. Dunlap	1940
University of Colorado School of Nursing Boulder, Colorado	Mrs. Pearl Parvin Coulter Director of Public Health Nursing	Mrs. Pearl Parvin Coulter	1942
University of Hawaii College of Applied Science Department of Nursing Honolulu 10, T. H.	Virginia A. Jones, Chairman Department of Nursing	Virginia A. Jones	1935 (approval discontinued, 1943) 1944
University of Michigan School of Public Health Department of Public Health Practice Ann Arbor, Michigan	Ella E. McNeil Professor, Public Health Nursing	Ella E. McNeil	1920
University of Minnesota School of Public Health 121 Millard Hall, University Campus Minneapolis 14, Minnesota	Margaret S. Taylor, Director Course in Public Health Nursing	Margaret S. Taylor	1920
University of North Carolina School of Public Health Department of Public Health Nursing Medical Building, University Campus Chapel Hill, North Carolina	Ruth W. Hay, Head of Department of Public Health Nursing	Ruth W. Hay	1942

[a] From 1920 through 1941 approval was considered retroactive for the two-year period prior to year of official action.
[c] Retroactive to 1940.

University or college and location	Address inquiries to:	Public health nurse faculty member in charge of program	Year of approval of program*
University of Oregon, Medical School School of Nursing 3181 S.W. Sam Jackson Park Road Portland 1, Oregon	Eleanor Palmquist Assistant Director in Charge of Public Health Nursing Programs	Eleanor Palmquist	1921
University of Pennsylvania School of Nursing Department of Nursing Education 3629 Locust Street Philadelphia 4, Pennsylvania	Theresa I. Lynch, Dean School of Nursing	Adaline Chase Associate Professor of Nursing Education	1936
University of Pittsburgh School of Nursing Pittsburgh 13, Pennsylvania	Dr. Dorothy Rood Chairman, Department of Public Health Nursing	Dr. Dorothy Rood	1922 (approval discontinued, 1924) 1942
University of Puerto Rico School of Tropical Medicine Division of Nursing Education San Juan, Puerto Rico	Celia Guzmán, Director Program in Public Health Nursing	Celia Guzmán	1948
University of Rochester Department of Nursing Education 31 Prince Street Rochester 3, New York	Catherine C. Brophy, Director Public Health Nursing Program	Catherine C. Brophy	1949
University of Washington School of Nursing Division of Public Health Nursing Seattle 5, Washington	Kathleen M. Leahy, Director Public Health Nursing Program of Study	Kathleen M. Leahy	1921
University of Wisconsin School of Nursing 1402 University Avenue Madison, Wisconsin	Martha R. Jenny Associate Professor of Public Health Nursing	Martha R. Jenny	1941 (approval discontinued, 1943) 1947
Vanderbilt University School of Nursing Nashville 4, Tennessee	Julia Hereford, Dean School of Nursing	Helen M. Howell Associate Professor of Public Health Nursing	1932
Wayne University College of Nursing 5257 Cass Avenue Detroit 2, Michigan	Katharine Faville, Dean College of Nursing	L. Ann Conley Associate Professor of Nursing	1931

* From 1920 through 1941 approval was considered retroactive for the two-year period prior to year of official action.

University or college and location	Address inquiries to:	Public health nurse faculty member in charge of program	Year of approval of program[a]
Western Reserve University Frances Payne Bolton School of Nursing 2063 Adelbert Road Cleveland, Ohio	Ellen L. Buell, Director Programs in Public Health Nursing	Ellen L. Buell	1920

[a] From 1920 through 1941 approval was considered retroactive for the two-year period prior to year of official action.

The six colleges and universities listed below offer a collegiate basic program leading to a degree which prepares students for professional practice in public health nursing as well as other fields of nursing. The graduates of these degree programs are qualified for beginning public health nurse positions under supervision in public health nursing services. These programs are approved for public health nursing by the National Nursing Accrediting Service.

For further information write directly to the appropriate educational unit in nursing in the college or university, addressing the person indicated below.

University or college and location	Address inquiries to:	Public health nurse faculty member responsible for integrating public health nursing	Year of approval of program
Cornell University-New York Hospital School of Nursing 525 East 68 Street New York 21, New York	Virginia M. Dunbar, Dean and Professor of Nursing	Mrs. Margery Overholser Associate Professor of Public Health Nursing	1949
Skidmore College Department of Nursing 303 East 20 Street New York 3, New York	Agnes Gelinas, Chairman Department of Nursing	Irene Carn, Associate Chairman Department of Nursing	1944[d]
University of Washington School of Nursing Seattle 5, Washington	Mrs. Lillian B. Patterson, Dean School of Nursing	Mrs. Evelyn Burke Associate Professor of Nursing	1948
Vanderbilt University School of Nursing Nashville 4, Tennessee	Julia Hereford, Dean School of Nursing	Helen M. Howell Associate Professor of Public Health Nursing Advisor on Public Health Nursing to Basic Program	1945[e]
Wayne University College of Nursing 5257 Cass Avenue Detroit 2, Michigan	Katharine Faville, Dean College of Nursing	L. Ann Conley Associate Professor of Nursing	1950

[d] Retroactive to 1942.
[e] Retroactive to 1944

University or college and location	Address inquiries to:	Public health nurse faculty member responsible for integrating public health nursing	Year of approval of program
Yale University School of Nursing 310 Cedar Street New Haven, Connecticut	Elizabeth S. Bixler, Dean School of Nursing	Hedwig Toelle Associate Professor of the Social and Health Aspects of Nursing	1945*

* Retroactive to 1942.

Programs for Graduate Nurses which Were Formerly Approved by the NOPHN but Are No Longer Approved for Public Health Nursing

University or college and location	Year of approval of program	Year approval of program discontinued
College of William and Mary Richmond Professional Institute Richmond, Virginia	1920	1943
Fordham University New York, New York	1932	1941
Ohio State University Columbus, Ohio	1938	1940
Pennsylvania School of Social and Health Work Philadelphia, Pennsylvania	1920	1935
University of Iowa Iowa City, Iowa	1922	1925
University of Louisville School of Public Health Louisville, Kentucky	1920	1924
University of Missouri Missouri School of Social Economy St. Louis, Missouri	1920	1924
University of Texas Austin, Texas	1920	1924
Washington University School of Nursing St. Louis, Missouri	1930	1936

Reprints available from NOPHN, 2 Park Avenue, New York 16.

Peckham Today

While abroad in the summer of 1949 Isadora Denike, director of Student Health Service at Freedmen's Hospital, sent back enthusiastic reports of her observations at the Peckham Health Center in London. Recently, hearing Peckham had closed its doors, Miss Denike wrote for information. She received a reply from Dr. Innes H. Pearse, one of the medical directors of the center, which she generously shares with readers of PUBLIC HEALTH NURSING.

EVERYONE IN AMERICA will understand that the state of financial stringency of Britain after the war, together with the assumption by the state of many social responsibilities hitherto the concern of private individuals, has been sharply reflected in rapid shrinkage of private support for all voluntary organizations.

By March 1950 the Pioneer Health Center (or "Peckham Experiment" as it was better known) suffered the fate of financial eclipse and had to suspend its activities. Appeal was made to the Government and ways sought to find how the work of the Center could be brought within the existing administrative regime—in particular within the National Health Service—in such a way as to qualify for the necessary grants for its continuance.

Long deliberation has proved that there is no scope within the present administration for a *family orientation* of services, nor is there scope for the pursuit of the cultivation of health as an activity distinct from the prevention and cure of sickness.

From the research point of view it is not considered by the authorities that results so far published justify an effort to sustain at this juncture the new experimental field created, nor to retain the material about families collected as the first fruits of this research and prepared for future research.

It will be recollected that the Center which opened in 1935 had only four and one half working years before war broke out and all its work was stopped. The war once over, the old member families of the Center still residing in the district, which had been very badly blitzed, clamored for its reopening. The Executive Committee of the Center, feeling assured of the fundamental significance of the work, took urgent steps to reclaim its premises from the firm of munition workers and the Admiralty who were in wartime occupation. This was an act of great faith for at that time, although the Center's overdraft had been wiped out during the war, money was guaranteed for only three months' running. No one knew what the price of repairs and reequipment of the building would be, nor the time these would take to effect. No one could foresee the increase in salaries and labor costs necessary for running the Center. Moreover, new staff had to be assembled and trained for the work. The four years since reopening barely sufficed for overcoming these difficulties and gave no opportunity for publication of any specific results of research.

BUT THE FOUR postwar years nevertheless have been invaluable to the Peckham observers. These years have settled for us one all-important question. Had the apparent growth in the member families' capacity for competent and responsible action, as persons and as parents, observed before the war, been merely an evanescent and transitory appearance—due perhaps to the pervading influence of staff enthusiasm—or had it been a process of educational character, a true "growth" process irreversible in its nature?

The reassembling of old member families after the war (550 member families out of

(Continued on page A12)

Civil Defense

SPECIAL WEAPONS DEFENSE

The nation's communities, particularly large cities, must speed their civil defense plans, according to the manual "Health Services and Special Weapons Defense," just released by the Federal Civil Defense Administration. The manual describes the grim possibilities of attack by atomic, chemical, or biological weapons and how to combat them. Preparation for defense is essentially a civilian responsibility; the Armed Forces cannot be counted on for help.

Organizing the community

Every community has been classified in one of three categories: critical target areas—heavily industrialized cities or those with certain critical industries—mutual aid communities surrounding major cities; and mobile support communities, which lie beyond the mutual aid areas.

Local organization should start with the appointment of an area civil defense director and the community health service directors who will serve under him. Under the plan, as soon as the health service director has determined the category of his community, he will appoint a health service advisory council for technical advice in the development of his organization.

In critical target areas the civil defense health service will be as fully organized as possible. Maximum use will be made of existing health services within the city and in outlying communities. Close cooperation will be maintained with the state civil defense director who has final authority for disposition of manpower, resources, and funds.

The manual gives detailed suggestions for organizing such vital services as first aid, medical supply, radiological monitoring, chemical defense, evacuation, et cetera.

Mutual aid communities will organize as fully as their means permit with two objectives: to receive casualties and to provide health service teams when needed. The job of the outlying mobile support areas is to set up self-contained teams for mobile support. These would operate under state direction.

Possible casualties

Planning for the possibility of atomic attack must rest on these assumptions: A single atomic bomb exploded in the air without warning on a city with a population density of 13,000 per square mile would result in 120,000 casualties. Forty thousand would be killed outright or die within the day; another 20,000 would die in five or six weeks. Among the 80,000 living casualties, some with multiple injuries, there would be an estimated 48,000 burn cases, 40,000 cases of mechanical injury, and 16,000 of radiation illness. A network of 180 first aid stations with 17,000 first aid workers would be needed.

Handling casualties

Casualties would depend on the time of day of the raid, the season, the type of structure and topography, et cetera. As a ready method of estimating casualties, population maps of a city can be prepared together with transparent overlays drawn to the same scale on which circles should be drawn at half-mile intervals around a point representing a hypothetical ground zero of an attack. Figures of probable casualties would appear within each circle. In the event of an attack, the overlay could be put over the population map to estimate how many people had been injured and where first aid stations should be sent.

Immediately after an atomic raid, some fifty-seven mobile first aid units, set up in trucks or buses, would be stationed in a circle one and a half miles from ground zero—

the point immediately under the explosion—at intervals of one sixth of a mile. These would be reinforced by a second ring of thirty-nine stations set up two miles distant. Each first aid station would be manned by 2 physicians, 3 dentists, 3 nurses, 2 pharmacists, 15 first aid workers and nurses aides, 6 clerical assistants to keep account of the dead and wounded, and 150 litter bearers.

Of the casualties surviving the first day of the hypothetical raid, an estimated 26,000 would need hospitalization and extensive treatment. Assuming that 6,000 of these could be evacuated to outlying areas, some 20,000 others would have to be cared for within the area. Needed hospital space could be secured by evacuating as many hospital patients as possible to their homes or to remote hospitals and utilizing all available hospital space including conference and storage rooms as well as adjacent schools, hotels, gymnasiums, et cetera.

Blood and blood derivatives would be needed in vast quantities. Shipments of blood to attacked cities should be limited to type "O" (universal type) blood until such time as laboratories can set up cross-matching procedures. To build up supplies ahead of time, blood collection centers should be expanded and new ones set up.

Biological warfare

The handbook discounts extreme statements terming biological warfare either of little danger or a weapon capable of destroying whole populations. The truth lies between these views. Biological agents could be used effectively either through open warfare or sabotage. Overt attack might be carried out through creation of aerosol clouds of particles containing pathogenic agents released over cities by airplane or submarines. Saboteurs could develop a wide selection of pathogenic agents in secret laboratories. These could be introduced into water, food, and milk supplies or into the air in congested areas.

Defenses against such attack already exist in our health departments, bureaus of animal husbandry, and agricultural departments but need strengthening. Preparations should include: training of selected personnel in detection of such agents; an expanded system of disease and morbidity reporting; planning for rapid mass immunization programs; installation of air filters in air raid shelters; development of an epidemic intelligence service.

Chemical weapons

The most likely chemical weapons are the "nerve gases" which are almost colorless and odorless, may cause death in a few minutes to an hour, and are detected with difficulty. Gas attack might be delivered by bombs from enemy planes or shells or guided missiles from distant sources. The gas might be of the nonpersistent type, dissipated in a few hours, or the persistent type, lingering for days.

The gas affects those parts of the nervous system that control breathing and circulation. Symptoms of poisoning are breathing difficulties, nausea, vomiting, and, finally, convulsions. The patient is treated by an injection of atropine sulfate into the muscles of thigh, buttocks, or shoulder. Since immediate treatment is essential, manufacturers have been encouraged to develop a simple, first aid apparatus which the layman can safely use.

Civil defense preparation against this menace includes: provision of a simple, inexpensive type of mask for the general public in target cities; protective clothing for health service workers who may have to enter areas contaminated with the gas in liquid form; provision of filters in air raid shelters; and development in target areas of small chemical warfare sections familiar with the hazards of these gases.

The manual, which gives not a blueprint but broad recommendations which can be adapted to the needs of any community, may be secured for 60 cents from the U. S. Government Printing Office, Washington 25, D. C.

New Books
And Other Publications

THE COMMUNITY AND PUBLIC HEALTH NURSING

Edith Wensley. New York, Macmillan Company, 1950. 250 p. $3.50.

Since "The Community and Public Health Nursing" has been long awaited by professional workers and board and committee members in many fields, plans were made to secure reviews from several people, representing various interests, rather than one inclusive review. These are the first of these reviews. The others will appear in early issues.

Mrs. Wensley's book, undertaken for the National Organization for Public Health Nursing to take the place of the earlier Board Members manuals of 1930 and 1937, is not a book to be read and absorbed in any single, concentrated reading. Rather, it is a guide and reference book for the layman in public health nursing and for those who work with him; it is a yardstick for both the present and the future, a *measure* of the groups—the boards, councils, or advisory committees—which back the community's efforts to further public health and the nursing service which is such an important part of it. It evaluates and most wisely directs the individuals and the committees whose integrated best efforts may make for progress, as well as sound administration and practice.

In most compact, well digested, and easily understood form, it covers tremendously wide fields, not only the history of the movement, but a widening vista of the future, as indicated by new, highly organized combinations of effort—either current or beckoning—in any single community. In this day of awakened responsibility for the perpetuation and growth of the best in the American way of life the book can play a large part in helping all citizens who find in this phase of our need their opportunity to be helpful. It should be a must for the orientation of the freshman in such citizen participation and should be used as a freshener for the senior who wishes or needs the stimulation and guidance of newer, better insight into today's and tomorrow's ways of finding better health for the whole community.

—Mrs. Montgomery S. Lewis, *Indianapolis, Indiana.*

This easy-to-read book admirably fulfills its purpose of bringing about better understanding of the problems of public health activity and of acquainting public health nurses with their responsibilities to communities needing service, as stated by Dr. Ernest L. Stebbins in the preface.

Of equal importance and value is the book's broad and yet practical advice on how citizens can carry their indispensable share of the work involved in public health nursing activity. This is dealt with from the standpoint of the public health nursing service of a health department or other governmental agency, a voluntary agency, a voluntary agency in a combination service, and school boards and school nursing.

This partnership of professional and citizen strength is shown as the democratic way in which citizens can enhance and extend health services and at the same time build the public understanding of needs and of services on which adequate support can be based.

In concise and well organized fashion the author shows the interrelation and the interdependence of professional and lay leadership, and of trained staff and volunteer workers in the national, state, or local community.

The book focuses on the local community, with special reference to boards, committees, memberships, and relationships. The content and the format make it excellent for training and institutes. Sound principles of community organization are set forth with more

than usual persuasiveness. The relation of an agency's goal to the good of the total community and its evaluation in that light are well handled, as is the matter of interrelation of agencies.

Generic principles of administration are simply stated and their application shown directly and indirectly in the apt illustrative material throughout the book. The application of the findings of group dynamics research to the whole question of making committee meetings interesting and productive is extremely helpful.

The book merits the category of "must" reading for citizens and nurses interested in community organization for public health activity. It is of definite value to a much wider audience, and of special interest to groups in the broad field of health and welfare.

—ROBERT E. BONDY, *Director, National Social Welfare Assembly.*

COLLEGE PROGRAMS IN INTERGROUP RELATIONS REPORT OF STUDY

Lloyd Allen Cook, Director. Washington, D.C., American Council on Education, 1950. 365 p. $3.75.

Throughout the past decade there has developed an increasing sense of urgency regarding need for improvement in the quality and scope of democratic relationships both within our country and in its dealings with other nations. Our public schools have opportunity and responsibility for increasing understanding and appreciation of differences among people. That they have not met this responsibility fully may be due to failure on the part of teachers to practice and to help children learn the technics of getting along with individuals who differ from themselves in various respects.

This book is the first of a two-volume report of the College Study in Intergroup Relations, a project directed by the Council on Cooperation in Teacher Education of the American Council on Education during the years 1945-1949. It describes attempts in twenty-four colleges to relate teacher education to problems of race, creed, social class, nationality, and rural-urban backgrounds.

This report has significance for nursing. Although theoretically the profession considers itself free from discrimination against any race, color, or creed, some of its practices in providing educational and employment opportunity are still not completely democratic. As community workers, nurses need to be well prepared for effective participation in the improvement of intergroup relations.

—AMY A. MACOWAN, R.N., *Assistant Professor of Public Health Nursing, University of California School of Nursing, Berkeley*

SAINTS, SINNERS AND PSYCHIATRY

Camilla M. Anderson. Philadelphia, J. B. Lippincott, 1950. 206 p. $2.95.

Dr. Anderson presents in everyday readable language an eclectic theory of personality function and structure for the promotion of understanding of human behavior. The book is written for the general public and should be helpful in the recognition of the purposefulness of behavior.

The fear and the avoidance of anxiety are described as the common denominators underlying all behavior, individual and group. Chapter 2 deals with three general reactions to and ways of dealing with anxiety: conversion of anxiety into physical symptoms, destruction or annihilation of the anxiety-provoking agent, and withdrawal from the source of anxiety. These general reaction patterns are then described in greater detail and illustrated with case material.

The determination of personality structure by function and its formation through childhood experiences in family living, influenced by parents and other important people in children's lives, and affected by social and cultural factors, are discussed in succeeding chapters. The consistent nature of behavior patterns and the persistence of formerly useful behavior, although inappropriate to many new situations, are stressed.

Behavior which is out of keeping with the individual's concept of his character structure arouses anxiety which is experienced as guilt. Likewise, whenever the function of the psychological self image is disturbed the resultant anxiety is experienced as feelings of

helplessness, frustration, and outraged virtue. Unrealistic guilt and the sense of virtue are regarded as primary handicaps to the understanding of behavior and as deterrents to change. It is to the author's concepts of the origin and meaning of guilt and virtue that the title of the book is related.

Dr. Anderson's theory of behavior presented in the text is summarized step by step in the last chapter of the book, a helpful device for clarification and review.

—JULIA FREUND, R.N., *Public Health Nursing Consultant in Mental Hygiene, Maryland State Department of Health.*

THE NURSERY SCHOOL

Katherine H. Read. Philadelphia, W. B. Saunders Company, 1950. 264 p. $3.50.

If you are interested in understanding more about human behavior you will find this book good reading. It is directed towards meeting the needs of college students who use the nursery school as a laboratory for studying children's behavior. Not only college students, however, but also parents, nurses, and experienced teachers of nursery school and kindergarten and older children will find much help. No pat answers are offered. The book's strength lies in the clear analysis of behavior supported by excellent illustrations. Interpretations are based on sound mental hygiene, and a commendable feature is that along with this one's thinking gets a definite push in a positive direction. As the author goes along even the experienced reader welcomes the easy-to-comprehend and thoughtful definitions of "current terms" the meaning of which is too often taken for granted by those of us in the field of education. Welcome, too, are the lists of pertinent references at the end of each chapter—pamphlets, articles, and books. The only thing missing here is reference to some of the excellent motion pictures that contribute to study in this field.

This reviewer would have welcomed a more extended discussion of curriculum and environment, and questions also the choice of several of the illustrations in this section as not being typical of the age level discussed. This very readable and practical book, however, is full of nuggets of common sense and wisdom and should not be missed!

—EMMA D. SHEEHY, *Associate Professor of Education, Teachers College, Columbia University*

MATERNITY CARE IN TWO COUNTIES

Frank E. Whitacre and Ellen Whiteman Jones. New York, The Commonwealth Fund, 1950. 165 p. 50c.

This small volume is a statistical study of maternity care during 1940, 1941, 1943, and 1944 in two fairly comparable Southern rural counties where the health departments provided public health nursing services which included services at delivery. Public health nurses and county health officers operating or planning to establish similar programs will find here an abundance of objective data on the accomplishments of two such programs. They have in this book a means for measuring their own achievements or goals against real performance. The maternity care in the two counties of this study did not reach textbook standards for an ideal program either at the beginning or at the end of the study period, but it was better at the end than at the beginning, and public health nursing service was an important factor in the improvement.

Clear practical comments explain the significance in terms of the wellbeing of the patient of all the various elements in medical and nursing care studied statistically. These comments give life and interest to what might otherwise be merely "dry statistics."

—HESTER B. CURTIS, M.D., *Regional Medical Director, Children's Bureau, Federal Security Agency*

PUBLIC HEALTH

WHAT'S THE SCORE? Booklet prepared by the Committee on Administrative Practice, American Public Health Association, 1790 Broadway, New York 19, New York, 1950. 52 p. A most attractive pamphlet, illustrating ways in which the evaluation process is used by public health personnel to interest the community and secure support. The story is developed around the Evaluation Schedules and the Health Practice Indices.

(Continued on page A12)

FROM NOPHN HEADQUARTERS

BOARD AND COMMITTEE MEMBERS SECTION

A meeting of the Executive Committee of the Board and Committee Members Section was held in New York City on December 1 with the following members present: Mrs. Philip A. Salmon, Short Hills, N. J., chairman; Mrs. Gilbert Pingree, Grosse Pointe, Mich., vice-chairman; Mrs. Elizabeth H. Andrews, R.N., Boston, Mass.; Mrs. Francis M. Archibald, Elizabeth, N. J.; Mrs. Carl C. Aven, Atlanta, Ga.; Helen Bean, R.N., New York, N. Y.; Mrs. Joseph S. Bittenbender, Plymouth, Pa.; Mrs. Daniel N. Beers, Pittsfield, Mass.; Mrs. Lucille E. Chance, New York, N. Y.; Frances K. Crouch, R.N., Alexandria, Va.; Mary C. Crowell, Warren, R. I.; Mrs. Pierre F. Goodrich, Indianapolis, Ind.; Mrs. Lindsley F. Kimball, Manhasset, Long Island, N. Y.; Mrs. Paige D. L'Hommedieu, New Brunswick, N. J.; Mr. Fred H. Ludwig, Reading, Pa.; Mrs. Eleanor R. Mosher, New York, N. Y.; Mrs. Ralph Pappenheimer, Cincinnati, Ohio; Ruth E. Rives, R.N., Buffalo, N. Y.; Mrs. Charles Tipton, Olney, Md.

The committee decided that interpretation of NOPHN's work and membership promotion should be continued as a primary project for the Board and Committee Members Section in 1951. A subcommittee will prepare a series of program outlines describing various phases of the NOPHN program for use at board meetings of member agencies. The committee also decided to help spread news about the regional conferences which promise to hold much of interest and value for board members.

ABBIE ROBERTS WEAVER AWARD

Flora Patterson Ray, public health nurse in the Fannin County (Georgia) Health Department, received the Abbie Roberts Weaver Award and the commendation of "her people" at the annual meeting of the Georgia State Nurses' Association at Augusta in November. Mrs. Ray, who has devoted more than half her life to the improvement of health conditions, is the first recipient of the award which will be made annually by the Georgia Organization for Public Health Nursing.

Mrs. Weaver, in whose memory the award was created, organized the Public Health Nursing Division of the Georgia Department of Public Health and became its first director in April 1936. Her earlier work included organizing and teaching in the public health nursing course at George Peabody College and serving as assistant director of the Red Cross Rural Nursing Service.

A commissioner of roads, three pastors, two doctors, several civic club presidents, and a mayor were among Mrs. Ray's sponsors for the award. A mother of two grown children, Mrs. Ray has been filling various assignments in public health nursing in Georgia since 1932 and has been public health nurse in Fannin County since 1939. Her earlier experience included a year at Jane Addams' Hull Street House in Chicago and private duty nursing.

In presenting the award, Anna Fillmore, general director of NOPHN, pointed out that Mrs. Ray was nominated "because of her closeness to her patients and their families—young, old, those in trouble, all who needed her." Mrs. Weaver knew, she added, "that the real leaders in nursing—in public health nursing—are the nurses who stay close to patients and families—the nurses who do the nursing."

COLLEGIATE COUNCIL MEETING

The Collegiate Council on Public Health Nursing Education: a Section of the NOPHN met in St. Louis on October 29-30. Participants included thirty-eight faculty members

representing thirty-one universities with approved programs of study in public health nursing. Emilie G. Sargent, president of NOPHN, and several members of the NOPHN staff attended the meetings.

A major portion of the two-day meeting was devoted to two questions: What is the meaning of public health nursing as a specialized area of nursing service? What agreement can we reach regarding the preparation of nurses for this special field? After speakers had presented various points of view, the membership divided into four groups for further exploration. Since the time was too limited to reach satisfactory conclusions, it is planned to continue consideration of problems which emerged in the lively discussions.

Other activities of the meeting included a discussion by Marion Sheahan on regional planning and reports by Anna Heisler and Helen Fisk on field training resources. Under the leadership of Ellen Buell a group discussion was held on ways and means by which the literature on public health nursing might be increased.

The council passed two resolutions expressing gratitude to Miss Chayer and Miss TeLinde: To Mary Ella Chayer who retired recently as professor in nursing education, Teachers College, for her many contributions in the preparation of nurses for the field of public health nursing and for her willingness to accept responsibility for activities sponsored by the council and the NOPHN; To Ruth TeLinde, who has resigned as director of the Department of Public Health Nursing, Syracuse University, to return to the service field of public health nursing as an agency administrator, for her many services as vice-chairman of the council and member of various standing and special committees.

GUIDE FOR WORK CONFERENCES ON TUBERCULOSIS NURSING

"A Guide to Work Conferences on Tuberculosis Nursing for Graduate Nurses," prepared by the Joint Tuberculosis Nursing Advisory Service, summarizes the recommendations of a committee which met last April in New York under the auspices of JTNAS to formulate plans for state work conferences on tuberculosis nursing. Nearly every state in the union and the territories have technical advisers to help form planning committees for such work conferences.

The guide includes suggestions for the administration of conferences and outlines the content. The latter includes personal and psychological factors, the nature of tuberculosis, its prevention, general medical and surgical treatment, rehabilitation, and socio-economic factors associated with tuberculosis.

The pamphlet is available free from the Joint Tuberculosis Nursing Advisory Service, 2 Park Avenue, New York 16.

REGIONAL CONFERENCES

Plans for the programs at the regional meetings are now being made. These programs will be built on the questions sent by the members. Therefore we are anxious to have your advance registration forms and your suggestions for the meetings. The registration forms were sent with the Christmas issue of *Phn* and also appeared in PUBLIC HEALTH NURSING, January 1951. (See also pages 96 and A14.)

In each city in which meetings are to be held a local planning committee is collecting suggestions to send to the NOPHN staff. It is important that you send your own suggestions also so that they can be added to or combined with those of the local committee. Here is your chance to let us know what you'd like discussed. We are counting on hearing from you. Remember the dates and places: Omaha, Nebraska, April 4-6; Portland, Oregon, May 16-18; Providence, Rhode Island, April 18-20; and New Orleans, Louisiana, May 23-25.

NOPHN FIELD SCHEDULE—JANUARY

Marjorie L. Adams	Fairfax, Va. Harrisburg, Pa. Beaver Falls, Pa. Altoona, Pa.
Anne Prochazka	Topeka, Kansas.

NEWS AND VIEWS

VA COMMUNITY NURSING PROGRAM

The Community Nursing Program is an extension of the Home Town Medical Care Plan which provides medical care to the veteran in his home, by a fee-basis physician of the veteran's choice. This program provides a means to afford professional nursing care on a visiting basis in the homes of veterans. Professional nursing care, including instruction in the promotion of health, where indicated, will be available to the eligible veteran who needs such care in his home.

The patient's eligibility for home nursing service will be determined by the Veterans Administration hospital or regional office. It is necessary that the veteran live in a locality where such service can be contracted for and that he or she be under medical direction. Nursing care in the home will be given under medical direction of a fee-basis physician, regional office physician, or a Veterans Administration hospital physician. Such care must be authorized by the Medical Division of the Regional Office. Requests for authorization of visits may be made by the community nursing agency directly to the chief medical officer, regional office clinics.

All contractual agreements with community nursing agencies will be consummated by the Supply Service, Central Office, Washington, D. C. Such agencies preferably should meet the agency membership requirements of the National Organization for Public Health Nursing. As minimum requirements the agency must employ graduate registered nurses, have an elected governing body representative of the community which holds regular meetings, and have a medical advisory committee and approved standing orders.

Home nursing service will include bedside nursing care, treatments, hypodermics (intramuscular and subcutaneous injections) and rehabilitation instructions, following the prescription of the physician. Visits to all patients will be kept at the minimum number consistent with good nursing care. Agencies will be expected to carry out the usual public health nursing practice of teaching families to assist with care.

Copies of the various forms and reports will be sent to agencies with whom contractual agreements have been made. Copies will also be forwarded to state health departments. Community nursing agencies may obtain further information from the chief, Nursing Unit, of the local or nearest Veterans Administration regional office clinic.

REPORT ON CANCER FACILITIES

The nation now has many specialized services for cancer control, according to a report just released by the National Cancer Institute, Public Health Service. Designed as an information source book for persons engaged in cancer activities, the report, "Cancer Services and Facilities in the United States," lists 268 cancer detection centers, 165 diagnostic clinics, 631 clinics with both diagnostic and treatment services, 17 cancer hospitals, and 6 nursing homes for advanced cancer patients.

The report brings up to date material in earlier reports and provides new state-by-state information on such items as the availability of cytology test services, home nursing services, free tissue diagnostic services, and an analysis of state cancer laws.

Many states have passed legislation providing for the establishment of some state-supported service or facility, chiefly for the medically indigent cancer patient. Nineteen provide complete care for this group. Thirty-eight states and territories have some type

of cancer registry in operation or in process of organization. All states except Nevada have facilities at which the cytology test may be obtained.

In some three fourths of the states some follow-up services for cancer patients are provided by public health nurses employed in health departments. The visiting nurse association is the chief agency from which cancer patients may secure parttime nursing service in the home. Leading the country in the development of this type of program are the New England States with visiting nurse service in more than 300 cities and towns.

The report, PHS Publication No. 14, may be secured from the U. S. Government Printing Office, Washington 25, D. C., for 35 cents.

PREVENTION OF CHRONIC DISEASE

The Commission on Chronic Illness has called a conference to be held in Chicago, March 12-14, 1951, to explore ways of preventing chronic disease. The delegates to this working conference will include representatives of national voluntary and official agencies, professional organizations, and individuals from the many fields which are concerned with the problems of chronic illness.

The discussions will be based on present-day scientific knowledge regarding prevention and early detection of the major chronic diseases. Emotional factors, malnutrition, heredity factors, and occupational causes of chronic diseases will be considered.

The U. S. Public Health Service and the National Health Council join the Commission on Chronic Disease in sponsoring the conference. Dr. Morton L. Levin, staff director of the commission, will direct the conference. He will be assisted by Mrs. Lucille M. Smith, USPHS.

COMMITTEE ON CAREERS

A March of Dimes grant of $22,000 has been made to the Committee on Careers in Nursing by the National Foundation for Infantile Paralysis which is actively supporting the recruitment of nurses. The grant will enable the committee to expand its recruitment program and continue the development of recruitment materials.

That the combined efforts of recruitment groups are bearing fruit, recent student admissions indicate. In 1950 a total of 44,185 first-year students, the largest group in five years, were admitted to the nearly 1,200 state-approved schools offering basic nursing programs. This figure exceeds by 1.3 percent admissions for the preceding year, which set a peacetime record of 43,612.

The 1950 figures showed a continuation in the trend, apparent for several years, towards a change in time of admissions. Between July and December, admissions totaled nearly 1,800 more than in the last six months of 1949, but between January and June 1,200 fewer students enrolled.

Increases in student admissions were reported in twenty-two states, approximately half of these in the Middle Atlantic, East North Central, and West North Central sections. Enrollment was heaviest in Massachusetts, New York, Pennsylvania, and Illinois, while the largest percentage increases were in Mississippi and Louisiana. A decrease in admissions over 1949 was reported in twenty-six states, seventeen of them in the southern and far western sections of the country.

"CANCER SOURCE BOOK FOR NURSES"

The source book, a comprehensive study of cancer by body sites, was recently published by the American Cancer Society. The primary aim of the illustrated, compact book is to provide basic and authoritative information about cancer. It does not discuss nursing care technics.

Dr. Charles S. Cameron, medical and scientific director, ACS, in the foreword says: "If cancer control is to make the progress so urgently called for, the nurse will have to assume more and more responsibility, as a community minded citizen, for the development of broad cancer education programs for the general public. . . . Because of her intimate relationship with many people the nurse has an obligation to develop a high threshold of suspicion where cancer is concerned."

The book discusses the nature of cancer, predisposing causes, symptoms, diagnosis, treatment, psychological aspects of the care

of the patient with cancer, and care of the terminal patient. Emphasis is put on the different problems for nursing care presented by cancer of different sites.

Copies of "A Cancer Source Book for Nurses" are being distributed to nurses through the local and state division offices of the American Cancer Society.

● The International Council for Exceptional Children will hold its 1951 convention April 18-21 at the Hotel New Yorker in New York City. Program details may be secured from the council, 1201 16 Street, N.W., Washington 6, D. C.

● The Communicable Disease Center, Public Health Service, in Atlanta, Georgia, announces that the spring Field Training Course in Epidemiology for Public Health Nurses will start February 19. The three months' course will include academic training and supervised field experience. While the course is free, nurses must pay their own expenses. For applications and further information write the Medical Officer in Charge, at the center.

Enrollments

A total enrollment of 4,308 students has been reported for the 1950 fall period by thirty-eight colleges and universities offering educational programs in nursing approved for public health nursing by the National Nursing Accrediting Service. Data were secured by the NOPHN by questionnaire. Thirty-five colleges and universities with educational programs for graduate nurses preparing for public health nursing report 3,498 fulltime and parttime enrollments, a decrease over the figure for the 1949 fall period. However, the six colleges and universities offering collegiate basic programs reported 810 enrollments, which is an increase.

In graduate nurse programs

Enrollments decreased for both fulltime and parttime students over those for the fall of 1950. The decrease was greater among fulltime students. Twenty-one schools had fewer fulltime enrollments, seven reported increases, and seven no change.

Colleges and universities reporting a decline in fulltime enrollments attributed it to a decrease in students receiving benefits under Public Law 346 (GI Bill of Rights), the present wartime need for nurses, the increase in the cost of education and of living, a decrease in scholarship aid available to students, improved methods of student selection, such as acceptance of students for degrees only, and various other causes.

The seven colleges and universities with higher enrollments gave such reasons as the desire of veterans to take advantage of the GI Bill of Rights before they become ineligible, the ability of the field to handle a larger number of students, and a demand on the part of agencies for better qualified personnel.

Parttime enrollments in graduate nurse programs decreased in sixteen colleges and universities over those for the fall of 1949, increased in eleven, and remained the same in eight. Schools reporting decreases gave such reasons as a decline in the number of veterans eligible for study under the GI Bill of Rights and limitations in the courses offered. The eleven schools with higher enrollments of parttime students gave as reasons a decrease in fulltime students, the employment of additional teaching staff which expanded facilities for evening classes, new offerings leading to a master's degree, and various others.

In collegiate basic programs

There are indications that enrollments in colleges and universities offering educational programs for collegiate basic nursing students are increasing. Schools reporting increases gave such reasons as improvement in the public relations programs, better recruitment, and provision of a fulltime counselor. One university reported that it had enrolled two freshman classes, one for a three-year professional program leading to a degree and one for a four-year integrated academic and professional degree program.

Our Readers Say . . .

MORE ON THE BRITISH HEALTH PLAN

I promised to send you a report about my rovings. I enjoyed my Scottish trip greatly. You know Scotland is a beautiful country with only five million inhabitants. In my three weeks' visit from border to border I was most impressed by the cheerfulness of all whom I met. The Scots truly enjoy life as it comes. They have delightful times together and never bemoan or even mention their troubles.

The most striking feature was the lovely, healthy-looking children who are so happy and contented. Everywhere we went the children seemed so secure. Regardless of locality, even in the most congested sections, there were nearby playgrounds with simple sturdy equipment that the children used without supervision. A log ten or twelve feet long, smooth, and suspended by heavy chains from a substantial frame, would have four or six laughing children astride and swinging. There were many types of amusements and many children stopped by on their way home from the store or from school for a few minutes of play.

Glasgow and Aberdeen, as well as the smaller cities, have housing projects that extend into the suburbs. There are few if any large apartments but many two-, four-, six-, or eight-family units. All have plots of land for the ever-present garden of vegetables and flowers. Tomatoes are grown under glass and the majority of the homes have glass-enclosed sheds for their tomato plants.

I talked with a few doctors and nurses, including a Queen's nurse, to learn a bit about their health plan. During the war food rationing with planned care for the expectant mother, the new mother, and the young child laid the groundwork for improved child care. That plan has changed very little and the National Health Act is superimposed on this sound basis. The nonprofessional people whom I met laughed a good deal about the national health plan but in the main they approved of it.

They thought there were a great many abuses and details which should be corrected. One is always hearing about wigs. Apparently bald men have revolted and although they have faced the world baldly for twenty-five to forty years they now request wigs—which somehow may be secured under the Health Act. And it isn't a question of one wig either. They come in pairs, one for wearing while the other is being refurbished. Women too are making demands, not for wigs but for corsets—surgical ones, it is true, but many are using surgical corsets without benefit of surgery. Everyone thought the doctors were getting the short end, whereas dentists were making out very well.

Of course I tried to ascertain some facts regarding these rumors. I found that in Scotland the general practitioner with a panel of 3,000 patients is paid sixteen shillings ($2.40) per person. In England I understand the doctor is paid eighteen shillings per person. Prices today are inflated and the doctor has to pay the same prices as the rest of his countrymen. In addition, he must keep up his car and his office, employ assistants, and purchase special instruments and equipment. His record work is prodigious.

The average general practitioner who is well liked and competent finds that he has additional patients as it is the patient's privilege to transfer his card. For $2.40 the doctor makes as many visits as his patient needs, be it one or two hundred in a year. Of course you may argue that not all 3,000 persons on his panel are sick. One young mother told me she hated to go to her physician's office because it was so crowded and she hesitated to ask for a house call because the doctor was so badly overworked. But, because he is such a good doctor she and her husband do not want anyone else, so they call only for very acute illnesses.

The dentists are paid by work per patient and as a result seem prosperous compared to the physicians, even those in the same town.

The district nurses are paid better than formerly and thus are more secure financially. However, many are on duty preposterously long hours—"until the work is done." Of course, the nurse who is a qualified midwife always has a caseload of deliveries in the offing. The government provides some extra educational facilities for the nurses but no more than previously, I understand. The nursing shortage parallels the medical shortage.

The doctors and nurses I met want the public to have good care and seem of the opinion that the health plan will continue. They hope the present mistakes can be corrected in order that more preventive public health work can be done. In any event, it seems a "noble experiment" which must pass beyond the experiment stage if young people are to be attracted to the medical and nursing professions.

MILDRED E. GONYEAU, R.N., *Director*
VNA, *Orange, New Jersey*

FORM FOR ADVANCE REGISTRATION

NOPHN Regional Conferences

Note: Do not send money. Payment of the registration fee of $2 for NOPHN members and $3 for nonmembers should be made in person at the conference. To secure the membership rate members must show their 1951 membership cards.

NAME .....
Please print

ADDRESS .....

CITY ..... ZONE NUMBER..... STATE.....

Meetings you plan to attend (please check)

Omaha, Nebraska—Fontanelle Hotel
April 4, 5, 6

Providence, Rhode Island—Sheraton Biltmore Hotel
April 18, 19, 20

Portland, Oregon—University of Oregon Medical School Library, 3181 S. W. Marquam Road
May 16, 17, 18

New Orleans, Louisiana—Jung Hotel
May 23, 24, 25

Are you an NOPHN member Yes..... No.....

If NOPHN member Nurse..... General.....

Please attach list of questions and problems you would like discussed.

Please indicate need for a one-day conference on these special fields.

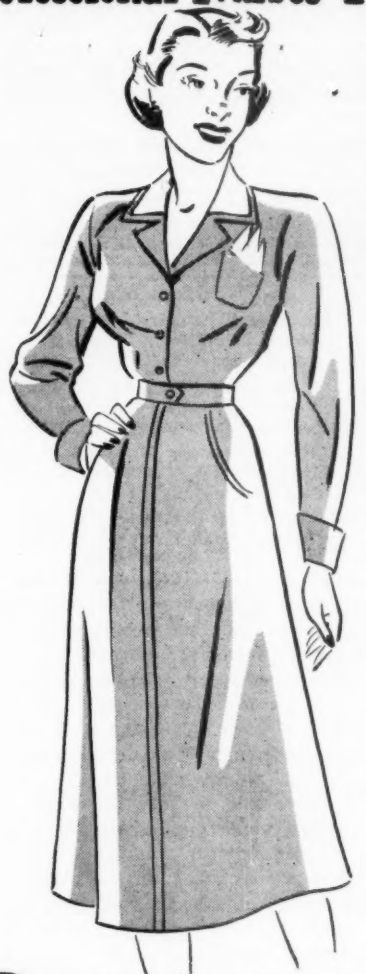
Mental Hygiene ..... School Nursing .....

Orthopedics ..... Tuberculosis .....

Fill out form and return to ELIZABETH STOBO, National Organization for Public Health Nursing, 2 Park Avenue, New York 16, New York.

Note: Kindly make your own hotel reservations directly with hotel of your choice in the city in which the meetings are to be held.

Professional Nurses Prefer . . .



UNIFORMS *by* Rosalia

Every ROSALIA Styled Uniform is a Masterpiece of meticulous workmanship, fine fabric and proper fit, to provide the professionally correct feeling and appearance of assurance.

It's important to every Professional Nurse to choose ROSALIA . . . Second-to-None UNIFORM VALUES, eager to be compared for Style, Quality and Price.

Public Health Nurse Uniforms are tailored by ROSALIA to your individual measurements.

Write today for 1951 Brochure of ROSALIA Distinctive Uniforms for Nurses.

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J. A. & R. E. SOLMES, Manufacturers
965 Arcade Street, St. Paul 6, Minnesota.

Please send me your 1951 Brochure of ROSALIA Uniforms for Nurses. No Obligation.

Name_____

Address_____

Town_____ Zone____ State_____

Books

(Continued from page 111)

NUTRITION

CALORIE REQUIREMENTS. Report of FAO Committee on Calorie Requirements. International Documents Service, Columbia University Press, New York 27. 1950. 65 p. 75c.

COMPOSITION OF FOODS—RAW, PROCESSED, PREPARED. U. S. Department of Agriculture Handbook No. 8. 1950. 147 p. Nutritionists, et cetera, may obtain free single copy from Office of Information, U. S. Department of Agriculture. Others may order from Superintendent of Documents, Washington 25, D. C., at 35c a copy.

GENERAL

CHEMISTRY, VISUALIZED AND APPLIED. Armand Joseph Courchaine. New York City, G. P. Putnam's Sons. 1950. 687 p. $5.50.

THE PERSON AS A NURSE. (Professional Adjustments) Florence C. Kempf. New York, The Macmillan Company. 1950. 226 p. $3.25.

HEALTH INSTRUCTION YEARBOOK 1950. Oliver E. Byrd. Stanford (California) Stanford University Press. 1950. 270 p. $3.50.

EVALUATION IN PHYSICAL EDUCATION. M. Gladys Scott and Esther French. St. Louis, C. V. Mosby Company. 1950. 348 p. $4.

Peckham Today

(Continued from page 106)

the 850 families in continuous membership when war broke out) has given us the answer. Though eight years had elapsed, they walked into the building as though they had left it the day before; where chaos had reigned among the children when we first opened, there was none—with the reopening at least, the only chaos was among the new staff but not among the members. Indeed, we found that those who were but children before the war and now returned as married couples were able at once to make better use of the center's facilities, both individual and social, than had their parents before them.

We were witnessing in these unique and new circumstances, an enhanced maturation of individuals and of families that had begun to appear as a result of a planned change in their environment. The time available to us has so far only sufficed to disclose that clinical methods in current use for the determination of "normality" and for the exclusion of disease are useless for assessment of the expression and quality of health. However interested in and eager for the fruits of this experiment we may be, it is not difficult to see that much time, skill, and knowledge are required to devise and test methods appropriate for the assessment and measurement of the newly observed phenomena.

Now that we have demonstrated how to collect families and present them with opportunities they can themselves make use of in spontaneous action, this work will no doubt be taken up in other countries less encumbered with financial burdens than Britain at the present juncture.

The outstanding fact is that the "experiment," based on the hypothesis that the family-in-its-home is the biological unit-structure of society, has demonstrated to those who have studied it closely that this hypothesis has complete validity in action. Whereas for the study of pathology the individual has so far sufficed, for the study of health no lesser entity than the "unity" of the family is of avail.

MEAT...and the PROTEIN NEEDS of the DIABETIC

Not less but *more protein* than the traditional gram per kilo of body weight recommended for the non-diabetic individual promotes an increased sense of well-being in the diabetic patient. Liberal amounts of biologically excellent protein, such as that provided by *meat,* are therefore especially useful in dietotherapy.

For supporting the well-being and vigor of the patient, increasing his resistance to infection, and minimizing many of the degenerative changes common in diabetes mellitus, maintenance of body protein reserves is particularly important.[1, 2] The former belief that protein foods, especially meat, engender hypertension and arteriosclerosis, is no longer tenable. On the contrary, deficits in dietary protein are apt to initiate anemia, hypoproteinemia, and retrogressive processes in the kidneys and other organs or tissues.

Ample amounts of high-quality protein foods in the prescribed diet—including generous amounts of meat—are important for maintaining a good nutritional state in the diabetic patient. Such a diet provides the nutritional essentials required in overcoming infections and in prompter healing of traumatic wounds.

Meat, however, is valuable to the patient for more than just its biologically excellent protein. It also furnishes important amounts of iron, thiamine, riboflavin and niacin, and of the newly discovered vitamin B_{12} which, among its several functions, promotes efficient utilization of protein.

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(1) Mosenthal, H. O.: Management of Diabetes Mellitus: An Analysis of Present-Day Methods of Treatment, Ann. Int. Med., 29:79 (July) 1948.

(2) McLester, J. S.: Nutrition and Diet in Health and Disease, 5th ed., Phil., W. B. Saunders Company, 1949, page 364.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

GOOD NUTRITION

l-e-n-g-t-h-e-n-s the Span of Health!

A longer *health* span, not merely a longer *life* span, is the goal of every adult. A recent authoritative article reviews nutrition problems in relation to aging.* Among the many essentials of good nutrition covered by the article are the amounts and kinds of food needed by older persons.

We are reminded that total energy requirements decrease with advancing years. The needs for certain food nutrients, on the other hand, are thought by some to *increase* even above those of earlier adult years. Thus, critical selection of foods which yield the maximum in nutrients for minimum return in calories becomes particularly important. Protein and calcium are frequently deficient in the diets of older persons. Failure of such persons to consume adequate amounts of dairy foods is a major factor in creating these deficiencies.

The article points out that: "Milk is not only a valuable source of protein but also a major source of calcium. . . . There is no reason whatever why the usual protein foods, such as milk products, cannot be employed to maintain adequate protein intake. . . . The major food sources of calcium are milk, cheese, ice cream, green vegetables, and legumes."*

In the main these generalizations for aging persons are in line with recently published findings of dietary studies and balance experiments on groups of older women.**

Long established dietary habits have a far-reaching effect on the nutrition of the aged. Certain foods are often routinely omitted because they are difficult to prepare or to eat. Dairy products, because they are liquid or relatively soft in consistency and can be used without preparation, lend themselves to the special needs of older persons.

*Stieglitz, E. J. *Nutrition problems of geriatric medicine.* J. Am. Med. Assn. *142*:1070 (April 8) 1950.

**Ohlson, M. A., Jackson, L., Boek, J., Cederquist, D. C., Brewer, W. D., and Brown, E. G. *Nutrition and dietary habits of aging women.* Am. J. Public Health *40*:1101 (Sept.) 1950.

The presence of this seal indicates that all nutrition statements in the advertisement have been found acceptable by the Council on Foods and Nutrition of the American Medical Association.

National DAIRY COUNCIL
111 N. Canal St., Chicago 6, Illinois

Since 1915 . . . the National Dairy Council, a nonprofit organization, has been devoted to nutrition research and education to extend the use of dairy products.

Gratis . . .

New 4-way approach to infant-nutrition for all your young mothers

4 sample boxes of cereals. An attractive educational unit that helps you impress young mothers with the need for a variety of pre-cooked cereals in Baby's diet. Gerber's "Quads" include Cereal Food, Oatmeal, Barley Cereal and the latest arrival, Rice Cereal.

Which is the starting cereal? When mothers ask which of Gerber's samples to begin with, your answer will, of course, depend on circumstances. The average baby can start on any of the 4 Cereals. If a need for hypoallergenic cereals is indicated, Gerber's Barley or Rice will probably be your first choice. Of comparable nutritional value, all Gerber's Cereals contain added iron, calcium and important B vitamins.

FREE Gerber's Cereal Samples and Baby Foods Analysis Folder. Write on your letterhead to Dept. PN 2-1, Fremont, Mich.

ACCEPTED COUNCIL ON FOODS AND NUTRITION AMERICAN MEDICAL ASSOCIATION

Babies are our business . . . our only business!

Gerber's
BABY FOODS

Cereals • Strained Foods • Junior Foods • Meats

How many undetected visual deficiencies in your school?

The MASSACHUSETTS VISION TEST

provides efficient vision screening for school children

It is no longer necessary to wait until a child has difficulty in school before discovering that he needs visual correction. Periodic examination with Massachusetts Vision Test equipment quickly reveals lack of keenness of vision, farsightedness, or muscular imbalance. Made only by Welch Allyn, this equipment is economical, simple to set up and operate and tests a large number in minimum time. Operator needs no previous experience or special training.

The Massachusetts Vision Test is approved by the Council on Physical Medicine and Rehabilitation of the American Medical Association and is now used by thousands of schools all over America.

WRITE FOR FREE BOOKLET

explaining the Massachusetts Vision Test and free reprint of the Women's Home Companion article "What is School Doing to your Children's Eyesight."

WELCH ALLYN, INC., AUBURN, N.Y.

The class that eats up art

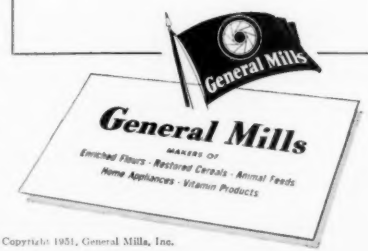
They thought they were just having fun, but the first graders of Athens Agricultural Schools, Athens, Michigan, were really learning about nutrition and art—the **easy** way. It started with posters—simple posters created by the children to tell the whole story of the Basic 7 Food Groups. Next the children tried their hands at place mats, decorating them with bright colors of their own design. Then they cut out food pictures from magazines and mounted them with stand-up backs. From this assortment of food pictures, they could practice assembling on their place mats many an imaginary "good lunch."

Mrs. Margaret Sleeper, art teacher for all twelve grades at Athens Schools, says, "There's no end to the opportunities to correlate art with nutrition study. It merely takes a suggestion, and pupils and teachers are off to a flying start with ideas contributed by all." For more news of what other teachers are doing to correlate nutrition with several subjects . . . for facts, ideas, plans, materials adaptable to any curriculum, write Education Section, Department of Public Services, General Mills, Minneapolis 1, Minnesota.

THINGS TO DO

in correlating art and nutrition at different grade levels:

- Make food models of clay or papier-mâché. Paint them.
- Decorate lunchroom with posters, new curtains. Paint and rearrange furniture.
- Provide table decorations for the lunchroom.
- Make nutrition displays for corridors.



POSITIONS AVAILABLE

Advertisements in this column are accepted at the following rates: 10c a word with a minimum of $3 for 30 words or less, MONEY TO ACCOMPANY ORDER FOR INSERTION. Agency members or sustaining members may have ONE insertion up to 50 words without charge. Closing date for copy and cancelation is the 1st of the month previous to publication.

POSITIONS AVAILABLE IMMEDIATELY:
PUBLIC HEALTH NURSE, SENIOR, $385 a month
PUBLIC HEALTH NURSE-MIDWIFE, $385 a month
PUBLIC HEALTH NURSE, $370 a month
Annual monthly increment of $15 through five pay grades; 15 percent Interior Differential for placements in Interior Alaska where cost of living is higher. All must have completed an approved course of study in public health nursing, and nurse-midwives a course in midwifery; public health nurses and public health nurse-midwives must have had at least one year of generalized public health nursing experience; senior public health nurses two years; retirement plan, 30 working days annual leave a year; 15 days sick leave. Write to Director, Nursing Division, Alaska Department of Health, Juneau, Alaska.

WANTED—Assistant director, Division of Nursing; position available immediately in Anchorage Branch Office of Alaska Department of Health; starting salary $6,624; minimum requirements: college degree including or to which has been added approved program of study in public health nursing; two years of generalized experience plus two years administrative or supervisory experience in public health agency; liberal personnel policies. Write to Dorothy Whitney, Director, Nursing Division, P.O. Box 1931, Juneau, Alaska.

WANTED—Supervisors and public health nurses, Baltimore County Health Department. Population 256,000; suburban, industrialized, and rural areas; county seat eight miles from Baltimore. Generalized service including progressive school health program; 50 field nurses; one month vacation; 5-day, 35½-hour week; sick leave; retirement plan; allowance of 7c a mile for use of personal car. Supervisor: degree and experience required; beginning salary $3,600-$4,000, depending on qualifications; additional preparation in fields of education, tuberculosis, orthopedics, or mental hygiene preferred. Public health nurses: beginning salary $2,300 (for trainee) to $2,700, depending on experience and education. Write to Dr. William H. F. Warthen, Health Officer, Baltimore County Health Department, Towson 4, Maryland.

WANTED—Nurse with public health training and experience: rural Connecticut; one-nurse agency near larger cities; general and school health program; active board; good personnel policies; adequate salary with annual increment. Give training and experience in first letter. Apply Box 251, NOPHN, 2 Park Avenue, New York 16, New York.

WANTED—Experienced field supervisor, immediate opening. Salary range $300-$325, depending on qualifications; vacation, sick leave, and retirement; continuous inservice training program. Write to Medical Director, J. B. Eason, Spokane City Health Department, Spokane, Washington.

WANTED—Public health nurses, junior, for generalized county nursing service. Salary range $250-$310 a month, plus travel allowance; registration in Texas or eligibility to secure registration required by Merit System; 5½-day week, two weeks annual vacation, two weeks sick leave; ability to speak Spanish desirable but not required; completion of at least three months approved course in public health nursing and six months full experience under qualified supervision, or completion of one year approved course of study in public health nursing required. Write to Dr. Fred O. Tonney, Medical Director, Cameron County Health Unit, San Benito, Texas, or Mrs. Maude Lorance, R.N., Director of Nursing Services, same address.

Public health nurses, senior, for generalized county nursing services. Salary range $275-$350 a month, plus travel allowance; minimum qualifications same as above, plus completion of one year approved course of study in public health and one year experience in public health nursing under qualified supervision. Write to Cameron County Health Unit, San Benito, Texas.

WANTED—Qualified staff nurses, nurse and non-nurse physical therapist, for visiting nurse association; program includes care of the ill in their homes, maternal and child hygiene, mothers' classes, rehabilitation, and physical therapy; salary dependent on education and experience; 5-day week; liberal holiday, vacation, and sick leave allowance; university facilities available locally for educational plans; immediate placement. Write to Ruth E. TeLinde, Executive Director, Visiting Nurse Association, 1038 North Cass Street, Milwaukee, Wisconsin.

WANTED—Public health nurses, general rural program. Salary: public health nurses, $2,652-$3,336; graduate nurses as assistant PHNs, $2,340-$2,772; $20 monthly car rental plus upkeep; 5-day week, vacation, sick leave, and retirement benefits. Write to Hazel Higbee, State Health Department, Richmond, Virginia.

New York City needs public health nurses. Vacancies in Health Department. Generalized service including maternal and child care, school health and communicable disease control. Immediate appointment on provisional basis. Starting salary $2400; 37 hour week; liberal vacation allowance; in-service training. Write: Bureau of Public Health Nursing, City Health Department, 125 Worth Street, New York 13, N. Y.

WANTED—Staff nurse desiring experience in generalized program in southern Michigan, between Chicago and Detroit; salary range $3,000 to $3,300, depending on qualifications and experience; depreciation and mileage allowance on own car; four weeks vacation yearly, liberal sick leave; field training area for public health nurses. Write to the Medical Director, District Health Department, Coldwater, Michigan.

WANTED—Supervisors and public health nurses for combination agency (voluntary and official) in metropolitan Columbus, Ohio; capital city, population 400,000; generalized service, including bedside care; two weeks vacation; 38½-hour week; two weeks sick leave; retirement plan; allowance 8c a mile for use of personal car; supervisor's salary $3,240-$3,504; NOPHN qualifications required; additional preparation in fields of education, tuberculosis, orthopedic, and mental hygiene preferred; public health nurse salary $2,844-$3,108, completion of an approved program in public health nursing required; professional nurse, no experience, $2,646-$2,778; orthopedic supervisor and nutrition consultant, salary $3,840-$4,000, depending on qualifications; salary increase for high cost of living anticipated. Write to Miss Mable E. Grover, Director, Instructive District Nursing Association-Division of Nursing, Columbus Department of Health, City Hall, Columbus 15, Ohio.

WANTED—The American Red Cross offers excellent employment opportunities as nursing field representative for nurses qualified in the field of public health education. Qualifications: bachelor's degree in public health nursing, nursing education, or health education, with at least two years of experience. Openings are available in the various sections of the country. Salaries are commensurate with training and experience. Inquiries should be directed to Mr. Raymond R. Fisher, Administrator for Personnel Services, National Headquarters, American National Red Cross, Washington 13, D.C.

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